THE CANADIAN NURSE

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LUME 53 NUMBER 10
MONTREAL

Highlight for
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MILDRED E. KATZELL

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L'Infirmière canadienne

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TO THOUSANDS OF CANADIANS scattered across our land there is nothing vague or confusing when a nurse says she comes from "The Island." Even in British Columbia where the use of the term might so easily refer to Vancouver Island, that is many times the size of our tiniest province, "The Island" is always Prince Edward Island.

Guest editor **Ruth Isobel Ross** is an Islander by birth and inclination though she journeyed far afield for her professional education. A graduate of Royal Victoria Hospital, Montreal, she received her public health nursing certificate from the McGill School for Graduate Nurses. She later completed the requirements for her degree at the University of Michigan, then went on to further postgraduate study in Health Education at the University of California. During the greater part of her professional career, Miss Ross has been on the staff of the Prince Edward Island Department of Health, with which was included her work as health instructor at the provincial normal school.

As president of the A.N.P.E.I., Miss Ross is very much aware of the problems that result from the very smallness of their association membership total. She realizes that there must be educational incentives and opportunities for the nurses in their own communities if they are to remain at their posts. Her editorial describes one such program.

* * *

Despite the fact many hundreds of Canadian nurses have secured their registration by passing the State Board Test Pool examinations, there is a startling lack of knowledge among them and others of just why this form of examination has been so widely adopted by our provincial nurses' associations. Many find it hard to understand why Canadian nurses should take licensing examinations developed in the United States. For the answer to this and other questions on the same subject, turn to **Mildred E. Katzell's** article. Mrs. Katzell is the director of the Evaluation Service of the NLN and an expert in the use of test pool examinations.

* * *

In no other field do nurses find it more difficult to keep abreast of developments than in the study of drugs and drug therapy. Even the pharmacists will admit to similar frustration. If you have been struggling with the names and functions of the latest ataractic agents or have been trying to sort out the newest members of the corticosteroid family, **J. E. Halliday**'s comprehensive summing up of these and other new compounds will be a comfort to you. He gave this address at the annual provincial meeting of the R.N.A.B.C. and we are pleased to be able to share his extremely useful and helpful material with you.

* * *

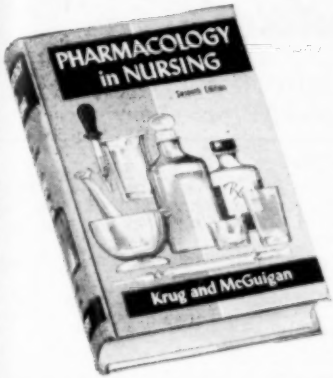
Each year numerous very fine addresses are given at graduation ceremonies in our schools of nursing. Much as we would like to print all of these and share their inspiration with you, space simply does not permit us to do so. But, as the well known exception to every rule, periodically an address reaches us that we feel must be shared. Such a one was the address given by **Moffatt St. A. Woodside**, Dean of the Faculty of Arts of the University of Toronto. The young women to whom his remarks were directed must surely have carried away with them a new appreciation of the worth of their profession and a renewed sense of dedication to it.

* * *

How many times have you questioned the necessity of twice-a-day temperature taking on afebrile patients? How often have you, inwardly if not openly, protested the interruption of meal hours on the ward by doctor's rounds, treatments or examinations? In our research section this month **Sister Mance Décary** and **Jacqueline Ouimet** present the findings of a project carried out at Notre-Dame Hospital, Montreal centred around problems such as those stated. The article is in the French language so polish up your translating ability or have a French-speaking friend read this section to you. Don't miss it! It is one of the most practical pieces of research that we have read lately.

Nothing prevents our being natural so much as the desire to appear so.

— *Maxim 431*



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Administration—By deep intramuscular injection. Suggested dosage is 40 mg. every 2 to 4 weeks or less frequently depending upon response. If response not satisfactory doses up to 80 mg. may be used.

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Oral route: usual dose is 5 mg. 3 or 4 times a day. Some patients may require more, i.e. 10 mg. 3 or 4 times a day. Only in the rarest instances should the total daily dose exceed 40 mg. When administered prophylactically or in mild cases, a single dose of 5-10 mg. is often sufficient.

Rectal route: 1 or 2 suppositories of 25 mg. per day. In patients suffering from intractable vomiting and unable to absorb a tablet, it is suggested to start treatment by the administration of one or two 25 mg. suppositories and then continue with oral doses.

Children: Over 2 years: 1 mg. per kg. body weight administered in divided doses. Over 12 years, the lower adult dosage is recommended.

Contra-Indications—Comatose or marked depression, due to central nervous system depressants.

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Manufacturer—Wallace Laboratories, 360 Adelaide St. W., Toronto.

Description—Meprobamate tablets of 400 mg.

Indications—Insomnia, anxiety and tension states, skeletal muscle spasm.

Administration—Insomnia, 2 tablets before retiring. Anxiety and tension, 1 or 2 tablets three times daily.

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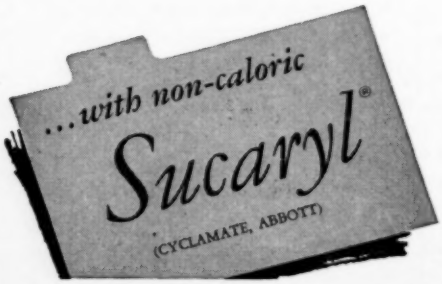

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THE CANADIAN NURSE

L'Infirmière canadienne

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Assuming Responsibilities

"THESE ARE THE DAYS of enlightenment and progress in all forms of social activity. Nursing is in the forefront of this progress," wrote Mlle M. Bihet, immediate past president of the International Council of Nurses.

Nursing today is exciting as well as progressive. Modern sociological and medical advances make it so. We nurses ask ourselves how we shall keep abreast of all this new knowledge so that we may be prepared to give the best nursing service and also fulfill our responsibilities to the nursing profession in this forward march. Refresher courses have been found to be one of the best ways to accomplish this.

The Association of Nurses of Prince Edward Island sponsored courses recently which dealt with the following: Mental health, maternal and child health, newer drugs, staphylococcal infections, trends in nutrition, present treatment of burns, and, of course, accreditation of nursing schools in Canada. Doctors, laboratory technicians, nutritionists and nurses worked together to extract newer knowledge in scientific advances essential to nursing, to learn modern nursing techniques and to enjoy relationships

RUTH I. ROSS

provided by group participation.

The theme of one recent refresher course was "Some Contributions of the Nurse to Medical Rehabilitation." This subject seemed timely as improvement in The Island's rehabilitation program is deemed essential. With the cooperation of Miss Kathleen Jackson, a widely experienced and tireless physiotherapist, a most productive institute of five sessions was held.

At the first session the definition of rehabilitation, the essentials for successful medical rehabilitation and the necessity of the patient shouldering responsibility for each step of his recovery were considered. The film "Condition Improved," produced in Canada, showed persons successfully rehabilitated into occupations.

A symposium of experts who contribute towards rehabilitation of the tuberculous patient then explained the unique contribution each makes from the time the patient enters the sanatorium until rehabilitated into a job or into satisfactory living. Thus the Provincial Director of Tuberculosis, a chest surgeon, nurse, physiotherapist, teacher and guidance counsellor helped us to realize what cooperative effort and good working relationships may accomplish.

"Our Provincial Sanatorium," filmed on Prince Edward Island, and "Papworth Village Settlement," a well-known rehabilitation project in England were shown.

A doctor next discussed treatments now generally prescribed for patients with rheumatic conditions and stressed the need of exercises graduated to the patient's medical condition to maintain joint function and to correct deformities in certain rheumatic conditions. Miss Jackson demonstrated these exercises and said that nurses could help patients to persist in prescribed exercises by interested encouragement.

The importance of early ambulation in orthopedic and general surgery was discussed by a surgeon. He advised that bed exercises before and on the first postoperative day are generally helpful to maintain and help restore bodily functions. Miss Jackson, assisted by nurses, again demonstrated exercises prescribed by the surgeon for specific surgical conditions. The film "Rehabilitation in Industry" was shown.

In evaluating this course in rehabilitation the nurses felt that two ideas gained were especially worthy of note:

1. The main purpose of exercise is the maintenance and restoration of function at the earliest time possible. This exercise should be taken in small amounts to prevent fatigue.

2. The nurse can help the patient realize that "it's not what is lost but what remains that must be made use of."

At a subsequent meeting a group of young graduates presented "New Fountains," a play about a girl who faces a crisis in her life after polio has made crutches necessary. Supported by friends and family, she eventually emerges victorious from her struggle between courage and fear, determination and dismay — a well rehabilitated teen-ager.

These post-basic programs help to keep nurses current with present scientific advances. We feel that they have the added value of stimulating the professional initiative of the younger nurses and therefore help them prepare for responsibilities in the progress of the nursing profession in Canada.

RUTH I. ROSS, B.Sc.
President
Association of Nurses, Prince Edward Island

Cirrhosis of the liver, long a fairly common chronic disease of adult life, now ranks among the 10 leading causes of death in the United States. At ages 45-64 the only diseases that outrank cirrhosis of the liver are heart disease, cancer and cerebral hemorrhage . . .

Emergence of cirrhosis as a leading cause of death resulted chiefly from the marked reduction in mortality from the infectious diseases. The increasing recorded death rate also may be due to improved methods of diagnosis and hence more frequent reporting of the disease on death certificates.

— Metropolitan Information Service

* * *

Most of our worries are about things that could happen; but seldom do.

Why Test Pool Examinations?

MILDRED E. KATZELL

EVER SINCE THE FIRST CANADIAN province began to use the State Board Test Pool Examination in the licensure of professional nurses during 1949, there has been considerable interest among Canadian nurses in this test service of the National League for Nursing. At the present time, six provinces have contracted to use the State Board Test Pool Examination during 1957, and a seventh province indicates that it hopes to use the service.

One might logically ask, as many people have, "Why should the Canadian provinces use the nurse licensing examinations developed in the United States? What advantages are there to be gained from this service which makes it preferable to our usual way of evaluating nurses for licensure?" These are good questions which deserve attention and careful consideration.

Before the development of the State Board Test Pool, each of the State Boards of Nursing in the United States constructed, administered, scored, and evaluated its own licensing examinations, in essentially the same way as was done in the Canadian provinces. During World War II, a number of factors combined to cause a change in this practice. The war situation brought increased pressure upon licensing authorities to register eligible nurses as quickly as possible after their graduation. It was necessary not only to construct these examinations, but also to score them promptly after they had been administered. This work had always been done by the registration authorities and leading nurses within the state. All of these persons were working under considerable pressure, and many had assumed extra responsibilities in nursing in order to fill the wartime need. In addition, schools of nursing found themselves with more students than before so that faculty had less time to contribute to the examination functions.

As a solution to these problems, a group of states approached the Voluntary Committee on Nursing Tests of the National League of Nursing Education (one of the predecessor organizations of the present National League for Nursing) regarding the possibility of working together on the planning and operation of a cooperative testing program. Considerable work was involved before the first examinations were available through the State Board Test Pool in 1944, but in that year the registration authorities of 23 jurisdictions* in the United States used the first examination. From this modest beginning, the service has grown until in 1957, 48 states, 2 territories and one federal district of the United States, and 6 Canadian provinces are using the State Board Test Pool Examination for Professional Nurses, 44 states and 2 territories of the United States, and one Canadian province are using the State Board Test Pool Examination for Practical Nurses.

Recent articles[1,2,3] have appeared elsewhere on the subject of the development of the State Board Test Pool Examinations, the study of scores from these examinations, and factors to be considered in the selection of a test service. The present article will not endeavor to duplicate those materials, but will attempt to describe the tests themselves and the possible values of participation in the Test Pool.

DESCRIPTION OF EXAMINATION

In recent years, the State Board Test Pool Examination for Professional Nurses has been composed of five parts, each yielding one score: Medical Nursing, Surgical Nursing,

Mrs. Katzell is Director of the Evaluation Service, National League for Nursing, New York.

*"Jurisdiction" is used as a general term referring to provinces, states, districts, and territories.

Obstetric Nursing, Nursing of Children, and Psychiatric Nursing. Questions in these tests deal with the care of patients and reflect the major aspects of basic programs in professional nursing. Some questions require the candidate to apply information learned in the instructional program to specific problems. Integrated into the five clinical tests are questions arising from anatomy and physiology, chemistry, microbiology, nutrition and diet therapy, pharmacology, nursing arts, communicable disease nursing, and social foundations of nursing.

Within each professional nurse test there are 100 to 120 questions of the multiple-choice objective type. Each question presents four alternatives, from which the candidate selects the best response, and indicates her choice on a separate answer sheet by making a black mark in a space which corresponds to the response she has chosen. The answer sheets are subsequently scored by an electrical machine. Two full days are required for the administration of the five tests.

Role of Boards of Nursing

Although the test service is provided through the National League for Nursing, participating Boards of Nursing or their nominees determine the abilities to be tested, develop the questions in the tests, and review the drafts of the tests. This review gives all Boards of Nursing the opportunity to indicate any questions they feel need to be revised or omitted. One direct advantage of this review is that it provides the Canadian Boards with an opportunity to identify questions which might be inappropriate for administration to candidates who have received their education in the provinces.

Besides their participation in the development of the tests, Boards of Nursing have complete responsibility for the administration of the tests and the evaluation of the test results. Test reports are provided to the Boards following each examination, showing the test scores of each candidate and also standard scores which indicate how each candidate's performance compares with that of the large number of candidates who have taken this examination. Each Board determines its own minimum standards for licensure and assumes responsibility for notifying candidates and, in some cases, schools of nursing of the action taken.

Advantages and Disadvantages

Recently, one Board of Nursing conducted a poll in its jurisdiction to learn the advantages which the faculties of their schools of nursing felt could be gained from participation in the Test Pool. A summary of some of their responses is presented here:

1. The widespread use of these examinations permits comparisons to be made from school to school and from jurisdiction to jurisdiction, expediting licensure in other states and provinces in these days of mobility.
2. The use of such examinations tends to promote uniform standards in schools of nursing so that the purchasers of nursing service know what minimum standard they can expect.
3. The breadth of participation in the construction and standardization of the examinations contributes to their high quality.
4. Because a large number of questions may be asked, a wider range of material can be covered in the same length of time.
5. The questions are objective and thought-provoking, and include the problem-solving and situation-type of question.
6. The use of these examinations promotes the teaching of principles rather than techniques.
7. These examinations relieve busy faculties of schools of nursing of the task of preparing and marking examinations.
8. There is no opportunity for bluffing on the basis of writing ability since the answers to each question are presented for the candidate to make a selection.
9. These examinations are more effective than our old essay-type of exams, and we find that they are no more costly.
10. The examinations are fairer to all schools and all candidates because a breadth of material is covered.

11. The separate machine scored answer sheets facilitate scoring and reporting.

12. Reports become available more promptly than was possible when the essay type of examination was administered to a large number of candidates.

The same jurisdiction asked the faculties of their schools of nursing to indicate disadvantages which might obtain from the use of the State Board Test Pool Examination. Some of these are indicated here, with comments which may clarify them:

1. It is impossible to evaluate the candidate's ability to express herself from an objective type test.

Those who favor the objective type of examination reply that there are other sources of information for the evaluation of verbal ability. Perhaps the school of nursing, in certifying that a candidate is ready for graduation, has some responsibility for evaluating the many aspects of preparation which cannot be adequately evaluated in any type of examination.

2. Objective type tests cannot measure the adaptability of the nurse, her practical ability, or her teaching ability.

The questions which might be raised here are whether any paper and pencil tests, essay or objective, could measure these areas of skill, and again, whether the school of nursing does not have the responsibility for evaluating those aspects of nursing education which cannot be adequately evaluated in an examination. Both objective and essay tests can assess whether the nurse knows what ought to be done. No written test can assess whether or not she will do it.

3. It is easier to guess on an objective type test than on an essay test.

This is true, but it is easier to bluff on an essay test. Provision is made in scoring the State Board Test Pool Examination to correct for guessing. This is done by subtracting a fraction of the number of incorrect answers from the total number of questions answered correctly. This correction in no way penalizes the candidate who knows the answers, but slightly reduces the score of the individual who has guessed. Correlations between scores obtained by counting only the number of questions marked correctly compared with scores obtained using the correction method are extremely high, indicating that the rank of a candidate is not significantly affected by the method used.

4. The faculty of the school of nursing is unfamiliar with the test content and cannot familiarize the students with the examination.

As a matter of fact, this objection is generally regarded as an advantage of the State Board Test Pool Examination. When faculty members have an opportunity to acquaint themselves with details of content of a test, there is always the likelihood that students will be prepared specifically for the examination rather than for nursing. For those schools which may wish to familiarize their students with the experience of taking a multiple-choice objective type test in nursing, achievement tests are available. The NLN Achievement Tests are of a type similar to the State Board Tests but include different content based on more inclusive objectives.

5. The test results are not available as promptly as if they were scored within the jurisdiction by the Board of Nursing or local faculty.

This is in direct contradiction to the twelfth advantage indicated above. Investigation of this objection has shown that in most instances Boards of Nursing receive the test results of the State Board Test Pool Examination more promptly than when the papers were scored by the Board. This is particularly true where large numbers of candidates have been examined. It is the policy of the National League for Nursing to issue the reports of the examinations within 15 working days after the test papers are received. During peak periods, the reports may be issued slightly later, but the general practice even at such times is to report results within 30 days of the last examination date or 15 working days.

Conclusion

Since 1944, the first year of the Test Pool Examination, participation in the Pool has grown from 23 jurisdictions to the present level of 57 jurisdictions. During the ten-year period from January, 1947 through December, 1956, over 320,000 candi-

dates have taken the State Board Test Pool Examination for professional nurses. During the same period, over 75,000 practical nurse candidates have taken the State Board Test Pool Examination for practical nurses. This growth in participation in the program is perhaps its strongest recommendation.

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1. "Studying State Board Test Scores," *Amer. J. Nurs.*, Vol 55, September, 1955.
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3. "How to Select a Test Service," *Nurs. Outlook*, Vol. 4, December, 1956.

In Memoriam

Georgine Badeaux décédait le 15 août, 1957 après une courte maladie. Née à Trois-Rivières, Mlle Badeaux fit ses études chez les Dames Ursulines de Gaspé. Après avoir terminé son cours d'infirmière à l'Hôtel-Dieu de Montréal, elle fit ses études comme infirmière hygiéniste et obtint une maîtrise en science sociale et politique de l'Université de Montréal. Sa culture, son jugement sûr et équitable lui valurent d'être chargée par l'Association des Infirmières de la Province de Québec de nombreux travaux et de la présidence du district de Montréal.

* * *

Vivian Esther Bonne who graduated in 1956 from the Winnipeg General Hospital died on July 22, 1957 at the Misericordia Hospital, Winnipeg as the result of injuries received in a car accident.

* * *

Christina Adelaide Cartier, a graduate from St. Paul's Hospital, Vancouver in 1914 died in San Francisco recently. Miss Cartier had been on the staff of the General Hospital in that city since 1940.

* * *

Pauline Elnicki who graduated from the Royal Columbian Hospital, New Westminster in 1951 died on July 23, 1957 in Vancouver after a long illness.

Mrs. Lettie A. Fairley, a graduate of the Children's Hospital, Buffalo, New York, died recently in Fort Erie, Ont.

* * *

Mary Jane O'Hare, who was a graduate of the Ottawa General Hospital, died on July 16, 1957 in Ottawa. Miss O'Hare spent much of her professional life on the staff of her home hospital.

* * *

Martha Gertrude Reynolds who graduated in 1888 from the Toronto General Hospital died at Port Hope, Ont. on July 23, 1957. She was 97 years old. Her professional career covered a period of 30 years and her memories dated back to the days of Sir John A. Macdonald whom she knew personally.

* * *

Sherolyn Osborne, who graduated from Royal Victoria Hospital, Montreal in 1955, died on August 19, 1957 in a level crossing accident near Abitibi, Que. She was 24 years of age.

* * *

Blanche C. Wright, a graduate of Glace Bay General Hospital in 1956 died recently as a result of injuries in a car accident.

Lift up one hand to heaven and thank your stars if they have given you the proper sense to enable you to appreciate the inconceivably droll situations in which we catch our fellow creatures.

— SIR WILLIAM OSLER

* * *

Total spending by governments in Canada on social security and health and welfare services now amounts to about one-third of all government spending.

— *Occupational Health Bulletin*

A device ressembling a fountain pen, that enables blind people to distinguish between light and shade and even between colors, will shortly be produced by the Biophysical Research Foundation in the U.S.A. It consists of a wire and a small amplifier attached to a photo-electric cell which transforms light into sound. Brightness of the light determines the intensity of the sound signal. The "pen" costs about $21 and runs on a 12-cent battery that lasts one year.

—*The World Veteran*

A Precious Kind of Leadership

MOFFAT ST. A. WOODSIDE, B.A. (TORONTO), B.A. AND M.A. (OXON)

YOU ARE NOW AT the great divide between student days, which should have been strenuous but reasonably carefree, and what is usually referred to on occasions like this as "the serious business of life" — whether that means practice of your profession, or home, husband and children, or both — at any rate business which should be both strenuous and happy. I propose, therefore, to tell you what at least one man-in-the-street thinks of nurses and expects from them. I shall certainly be preaching, but I know that I shall be preaching to the converted. Who ever heard of a young woman preparing herself for the nursing profession because of the short hours or large income expected? All of you have undoubtedly accepted, in some measure, consciously or unconsciously, the principles which I am about to state, otherwise you would not be here. However, there is perhaps some small advantage in attempting to formulate them once again, or to make them more precise.

A short time ago the poet A. H. Auden received the prize for poetry in the National Book Awards of the United States. A reporter, seeking copy, asked him a rather threadbare question and received a startling answer. "Do you write," asked the reporter, "for the critics or for the public or for yourself alone?" Auden replied, "Most of the people for whom I write are dead!" What he meant, of course, was that he drew his strength, his inspiration and his stimulus from the great poets of the past, and that it was their standards which he tried to meet.

This beautiful paradox of Auden's is so suggestive that I propose to apply it to you. In part, and in a certain sense, you will during your professional careers be living and working for people who are dead. Your professional education has given you full membership in a small but impressive society which stretches across the centuries. I shall give you only a few names from the membership list, but they will indicate the nature of the society as a whole. Socrates, who thought it less important to earn a living than to hold something worth dying for. Hippocrates who turned medicine into a science (and an art) and who said, "Where there is love of mankind, there is also love of healing." Jesus of Nazareth who considered the human individual so precious that he went to execution to demonstrate that all individuals and any individual at all is worthy of love. Ambroise Paré who said, "Je le pansai; Dieu le guérit." Galileo and Mme Curie. Bacon and Banting. And, of course, a group especially well known to you: Phoebe, Elizabeth of Hungary, Catherine of Sienna, Jeanne Mance of Montreal, Florence Nightingale, Mary Adelaide Nutting.

Although dead, these great men and women are in a sense alive and at work — vigorous and vital. For those of you who had eyes to see, they walked beside you down hospital corridors and in the wards. They spoke, faintly perhaps, to those of you who had ears to hear, in classrooms. They have been with you constantly as friends and associates, seeking to impart to you something of their strength and of their greatness and urging you to surpass what they have been able to do. They will never leave you unless you turn your backs on them. You must either live with them or without them. You have been admitted to their society; it is their standards which you will have to meet and which they hope that you will transcend. As the world goes, you are, for the majority, the only visible members of this society. Its reputation depends on you; you must never let it down. The responsibility could easily dismay women of the

This address was delivered by Mr. Woodside, Dean of the Faculty of Arts, University of Toronto, at the 1957 graduation exercises of the Toronto General Hospital.

greatest fortitude and toughness were it not for the fact that the senior members of the comparatively small society will always be at your elbow — so close that a quick turn of the head will almost reveal their presence — supporting, helping and encouraging you if you will let them.

You will, then, as I have tried to suggest, be working in a sense and in part for people who are dead. You will also be working for people who are alive and for people who are not yet born. I am not referring now to the doctors whom you will help, or to your children and grandchildren. It can surely be taken for granted that doctors will receive the best of help and patients the best of care and that you will be wonderful mothers and grandmothers. I am now talking about the wider way in which you will be called upon, as nurses, to serve society. Some years ago a painting by an English artist named Goetze enjoyed a measure of fame in England. One very distinguished Canadian artist has told me that he remembers queuing up on the street in order to see it. If you wish to view it, you will not have to travel to England, nor will you have to queue up. The picture is hanging in the Chapel of Victoria College, Toronto. I imagine that if I were a nurse I would like to look at it from time to time. The canvas is huge. The scene is laid in London, England — in that part which is known as "The City." In the centre, Jesus of Nazareth, adorned with a crown of thorns, is roped to a stone structure, bowed down by the weight of humiliation and sheer pain. A cross section of the city's population is portrayed. A demagogue addressing a crowd in the distance. A crowd of people passing by — a scientist, a scholar, a jockey, a miner, a newsboy, a mother with her child, a man and a woman in full evening dress, a bishop in ecclesiastical garb and academic hood, and so on. None of them is paying the slightest attention to the central suffering figure. The only exception is a person in the middle of the nonchalant crowd which is sweeping past. That person is a nurse. Her hand is caught to her mouth as she views the tortured figure with consternation, pity and love.

What does it all mean? I am sure that the artist has assumed the role of the man-in-the-street, and is trying, as I am trying, to state the part which nurses are expected to play in society. Professional competence and skill, yes, but something more, too. What is this something more? It is love. I don't mean sentimentality; I don't mean what is now commonly called "romantic love." I don't mean a form of weakness. I mean the quality of strength possessed only by great men and women, a quality which is universally admired in theory and imperfectly displayed in practice. Ask almost any intelligent person who is the greatest man in the world today and he is almost certain to say "Albert Schweitzer." Why? Because Schweitzer gave up several distinct and brilliant careers — as concert organist, as philosopher, as theologian — to serve the needs of his brothers, remote and black though they were. This is what I mean by love. Whether you accept it or not, and I am sure that you will accept it, the man-in-the-street regards the nurse as exemplifying in the highest degree the virtue of love. *A precious kind of leadership is deservedly recognized in nurses.* Because of this, the quality of the present and of the future depends in large measure on them and on their example. Other qualities have been given a more than fair trial and an exceedingly long run. Hatred, animosity, prejudice and suspicion have been universally practised for 6,000 years. The results have been impressive in the worst sense. The ideal of love has, of course, been enunciated for a long time. You will find it in the Hebrew prophets of the 8th century B.C. You will find it in some Greek philosophers. You will find it in the core of Christian doctrine. But so far it has *never* been tried in practice except by a comparatively small number of individuals. Society possesses here a source of potential power which defies measurement. We have made a beginning at tapping the resources of atomic energy; we have not yet started to liberate the power of love.

The meaning of all this, in practical terms, is surely clear. I am justified in taking it for granted that all of you, as nurses, will be motivated

by love — what other motive can there possibly be? — in dealing with those who come under your professional care. The public, however, will not regard you as professionally competent nurses and nothing more. The public will regard you as professional women, bound by the high ethics of your profession. It will also regard you as educated women — as women who have enjoyed educational opportunities beyond those of the vast majority. And a few thoughtful members of society will see that you have enjoyed these opportunities because, to be sure, you had the ability and the will to take advantage of them, but also because society was willing to provide you with them. Consequently society will regard you as extraordinary people, or in other words, as leaders. It will do you no good to say, "I am a nurse; I know nothing about race relations." "I am a nurse; I know nothing about juvenile delinquency." "I am a nurse; I know nothing about The Colombo Plan." Society will not accept such excuses because it will look to you for leadership in these areas, and it will look to you for leadership because it rightly identifies you with the virtue of love. If you are not now at home in these and similar areas, you must try to acquire the necessary knowledge. For if you, who by the nature of your profession are committed to a life of love, do not assume a measure of leadership, the cause of the angels will be deprived of strength that is unique.

You will thus, in a very obvious sense, be working for people who are alive. You will also be working for people who are not yet born; for if you can mend the temper of the times you will have established a bright new world for generation after generation.

I have certainly been preaching to you. But I would not have dared to do so had I had any doubt about your willingness to serve well the future and the present and to walk down the years, head high, looking God reverently yet confidently in the face, encompassed by so great a cloud of truly great witnesses who are dead, but still gloriously alive.

Three principal changes in its recommendations for prevention of first and repeat attacks of rheumatic fever are incorporated in a new edition of the American Heart Association's statement on "Prevention of Rheumatic Fever and Bacterial Endocarditis through Control of Streptococcal Infections."

The changes are:

1. Greater emphasis is placed on the value of throat cultures in diagnosing streptococcal infections.

2. A more qualified statement is made on the duration of prophylaxis. The Association's Committee on Prevention reaffirms its view that prophylaxis should be maintained indefinitely for known rheumatic subjects. It recognizes that some physicians may wish to make exceptions in certain of their adult patients, particularly those without heart disease who have had no rheumatic attacks for many years.

3. Monthly injection of 1,200,000 units of benzathine penicillin G intramuscularly is now listed first among prophylactic methods . . . If oral penicillin is chosen as the method of prophylaxis, 200,000-250,000 units twice daily, rather than once, provides an additional safeguard against breakthroughs, which have been reported with the smaller dosage.

Also revised are the recommended dosages for prophylaxis against bacterial endocarditis in patients with rheumatic or congenital heart disease. If obliged to undergo such surgical procedures as dental extractions and tonsilectomies, the Committee recommends that high penicillin blood levels should be maintained for several days — rather than on the day of operation alone.

— *Scope Weekly*

The life expectancy at birth among American wage earners and their families rose to a new high of 70.0 years in 1955 — the 12th successive year to record a rise . . . In 1879-94 the earliest period for which data are available, the average length of life was only 34 years.

White females have done better than males with the result that their life expectancy is greater than ever before.

— *Scope Weekly*

* * *

By taking periodic survey of the home from attic to basement, many unsuspected fire hazards could be discovered and remedied, to lower Canada's appallingly high loss of life and property in home fires.

—Dept. of National Health & Welfare

Fire and Helpless People

ROBERT MCGRATH

NURSES HAVE NOT BEEN completely satisfied with lecture and film sessions on hospital fire safety. They appreciate the value of fire prevention planning and fire protective installations, but most of them are concerned with what can be done "right now," if and when fire does break out. They are well aware that they will be on their own for a few minutes following the discovery of fire, so they have sought simple and satisfactory tactics that they themselves can apply before the arrival of the fire department.

Recent institutional fires in the United States and in Canada have resulted in over 100 fatalities. Besides the usual factors of carelessness, structural deficiencies, economic short cuts and general apathy, it is becoming more and more evident that too little knowledge about the emergency removal of the ill, the injured and the aged has added to the toll. Getting patients out in time and coping with the embryo fire are problems best handled by people who have had some previous practical training. It is easier to adjust basic principles to a perilous situation than to invent suitable techniques at the moment.

Working together over the past three years, hundreds of nurses and I have worked out a fire safety program which has spread to many hospitals. Progress has been laborious, yet grim and relentless, against a vacuum of tradition. The future looks more promising, with rank and file nurses exerting unorganized pressure against organized administrative resistance.

STARTING THE PROGRAM

When a group of nurses first approached me with problems relative to handling patients in a fire emergency, I had to confess that I was completely destitute of answers. My own rescue training was limited to the standard over-the-shoulder, all purpose fireman's carry that might not be compatible with prolonging the health and welfare of an orthopedic or post-surgical patient. I suggested to them that we might be able to find one or two solutions if they were willing to work with me.

They agreed and we set out to design new rescue methods and to redesign old ones that could be used on patients by nurses. When other nurses heard what we were doing they came over and worked with us on their own time. Over a period of several weeks we experimented with firefighting equipment and tested carries on stairwells and fire escapes. Finally, through trial and error, we were convinced that we had a workable program. It was divided into three phases — emergency patient removal, first-aid firefighting, and evacuation. We decided that proper application of the first two steps might make the third one unnecessary.

THE PLAN

Emergency patient removal consists of six basic carries that can be applied to any situation, depending upon the number of nurses available and patient conditions. There are three emergency removals for the nurse who is caught alone: two carries for a pair of nurses working together and finally a three-nurse removal which differs somewhat from the standard three-man method. There are at least 18 possible variations of the six basic carries.

First-aid firefighting includes the actual handling and use of equipment by the nurses. They are taught how to smother fires with carbon dioxide extinguishers that are designed for flammable liquid, oil, grease or electrical fires. They become proficient in the use of soda acid extinguishers on paper, wood, textile or rubbish fires.

Lt. Robert McGrath is Hospital Inspector with the Chicago Fire Department.

Single nurse removal

and adept at using hose lines on fires that require more than one or two extinguishers. They are taught to extinguish fires with blankets, sheets, nylon articles and newspapers because often it is more important to use something close at hand that to travel a great distance for an extinguisher.

The third phase of the program is called evacuation. It is a larger scale operation and is more retreat than rescue. It involves more of everything — more patients, personnel, area, movement. Evacuation can be horizontal into a safer adjoining area or building or it can be vertical via stairwells, safe elevators, or fire escapes. Leaving the building entirely is the last resort — something akin to abandoning a sinking ship.

Three nurse removal

Evacuation also necessitates the use of mobile equipment like wheel chairs, stretcher carts and even ambulances and trucks if movement to a temporary location is advisable. Emphasis should be placed on the uses of a blanket. It might be the most important piece of equipment in the whole hospital. With it we smother a small fire, drag a patient from a room, or use it as a stretcher on stairs and fire escapes. There are never enough stretchers when they are needed but blankets are plentiful for use either in hospital or community disaster.

Fire and Disaster Planning

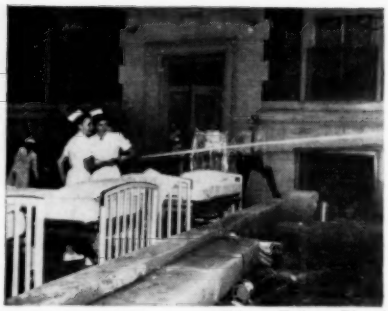
Nurses are efficient and methodical. They look for step by step mechanics arranged in one, two, three alignment — the briefer, the better. Nurses will not read 20 thousand words on disaster

(Dorothy Pinkham)

A blanket stretcher

planning — they are much too occupied. Such lengthy discourses should be reserved for key officials who have more time available for complicated planning.

A fire plan should be just part of a general disaster plan. A good fire program can be the first line of defense against flood, tornado or other natural disaster. People trained in fire and evacuation principles can easily follow the directions of officials and supervisors who may



(Chicago Tribune Photo)

Manning the hoses

know something about other types of emergency. The program should be as simple as the first three letters of the alphabet.

A. The patient or patients in immediate danger should be removed only as far as the floor in the corridor.

B. The alarm should be transmitted to get fire departments rolling.

C. An attempt must be made to subdue or control the fire.

Using a sheet

Failure of this interrelated sequence indicates the necessity for a general alarm and mobilization of all available assistance for evacuation. All the occupants of the threatened area plus the patient or patients on the corridor floor, should be led, wheeled or carried to a safer section. Evacuation can be a quick and orderly process if hospital personnel and fire departments are familiar with standard methods of removal.

In smaller towns it might be wise to train community disaster teams, particularly in the vicinity of hospitals, nursing homes and similar institutions. I have found that people are eager to do something with their hands yet are reluctant to lend their ears to information they disbelieve. When they are told to hit the road by some strategists and make like a mole by others, under similar conditions, they become skeptical of all pronouncements from top-level sources.

When I first began training them, grave doubts were expressed about the stamina and fortitude of nurses. Some rugged males suggested that an actual fire threat might inspire a rapid de-

(Chicago American)

The carbon dioxide extinguisher

parture to safer environs. ("The Natural Superiority of Women" had not yet been published.) Nurses in recent months, have saved several lives under severe fire conditions and have successfully engineered two mass evacuations. Thousands of nurses have now been trained in practical fire

A foam extinguisher

emergency procedures. In many cities the firemen and nurses are working together, learning together and helping to establish better survival odds for the helpless in case of fire. After three years of close contact with them, I may have been instrumental in helping some of them to become better nurses. I know my association with nurses has made a better fireman of me and perhaps a better person.

REFERENCE

Emergency Removal of Patients and First-Aid Fire Fighting in Hospitals by Lt. Robert McGrath. A joint publication of National Safety Council and the American Hospital Association.

Nurses' Permanent Rotation Schedule

BERTHA JENKINS

ONE OF THE most vexatious problems in the average hospital is to find some pattern of graduate staff rotation that will effectively provide adequate nursing care for all the patients on each shift and at the same time will be reasonably acceptable to all of the general staff nurses. In many institutions, the nursing staff works on a day-to-day schedule with little or no certainty of when they will be on which shift. This is a source of deep dissatisfaction to the nurses, of confusion and frequent serious staff shortages to the hospital.

At the General Hospital in Sarnia, Ontario, this state of near chaos resulted finally in the calling of a general meeting of all nurses to consider a definite schedule of rotation. They were not at all sure that it would or could work out satisfactorily. After a lengthy discussion, the nurses agreed to try it out for four months, with the assurance that at the end of that period a revision would be made if they were not convinced of the schedule's value. At a recent poll, 80 per cent of the staff said they would resign if they had to return to the day-to-day call system!

EXPLANATION OF SCHEDULE

This schedule is based on the necessity of having four nurses on a ward to cover the complete 24-hour working day, one on each shift and one to relieve. It seemed to work out better in 8-week intervals, and if you will refer to Sheet A and follow Nurse D through on this schedule, it will be easiest.

The schedule is based also on a 42-44-hour week — approximately four weeks of days, two weeks evenings and two weeks night duty. During both day and evening shifts, the nurse has one day off one week, and two days the next, and during the day run she gets a week-end off. She gets normal time off during the evening shift, but during the night shift she works straight through, and accumulates her days off.

You will notice that the nurse comes off duty on Sunday morning at 7:30, so that Sunday, to all intents and purposes, is a lost day for the hospital. Monday off, compensates for the first week of nights, Tuesday and Wednesday off compensate for the second week of nights, Thursday off compensates for the present week, and Friday is a statutory holiday which comes during the eight weeks. Since the evening shift has to have relief, it seemed a good idea to let this nurse relieve on the evening shift, so that she would not have to be ready for duty until 3:00 o'clock, which is another half day off duty.

Admitting that one statutory holiday every eight weeks amounts to 6½ statutory holidays a year, it was de-

Miss Jenkins is Director of Nursing of the Sarnia General Hospital.

PERMANENT SCHEDULE FOR GENERAL DUTY STAFF

Sheet A

For 4 Nurses

D: Day
E: Evening
N: Night
S: Statutory Holiday

1st Week

	M	T	W	T	F	S	S
"A"	-	-	-	-	S	E	D
"B"	E	E	E	E	E	-	E
"C"	N	N	N	N	N	N	N
"D"	D	D	D	D	D	D	-

2nd Week

M	T	W	T	F	S	S
D	D	-	-	D	D	D
E	E	E	E	-	-	N
N	N	N	N	N	N	-
-	-	D	D	E	E	E

3rd Week

M	T	W	T	F	S	S
D	D	D	D	D	D	-
N	N	N	N	N	N	N
-	-	-	-	S	E	D
E	E	E	E	E	-	E

4th Week

M	T	W	T	F	S	S
-	-	D	D	E	E	E
N	N	N	N	N	N	-
D	D	-	-	D	D	D
E	E	E	E	-	-	N

5th Week

	M	T	W	T	F	S	S
"A"	E	E	E	E	E	-	E
"B"	-	-	-	-	S	E	D
"C"	D	D	D	D	D	D	-
"D"	N	N	N	N	N	N	N

6 th Week

M	T	W	T	F	S	S
E	E	E	E	-	-	N
D	D	-	-	D	D	D
-	-	D	D	E	E	E
N	N	N	N	N	N	-

7th Week

M	T	W	T	F	S	S
N	N	N	N	N	N	N
D	D	D	D	D	D	-
E	E	E	E	E	-	E
-	-	-	-	S	E	D

8th Week

M	T	W	T	F	S	S
N	N	N	N	N	N	-
-	-	D	D	E	E	E
E	E	E	E	-	-	N
D	D	-	-	D	D	D

D: Day
E: Evening
N: Night
S: Statutory Holiday

PERMANENT SCHEDULE FOR GENERAL DUTY STAFF

For 6 Nurses

Sheet B

1st Week

	M	T	W	T	F	S	S
"A"	-	-	-	-	S	E	D
"B"	D	D	D	D	D	-	E
"C"	N	N	N	N	N	N	N
"D"	D	D	D	D	D	D	-
"E"	D	D	-	-	D	D	D
"F"	E	E	E	E	E	-	-

2nd Week

M	T	W	T	F	S	S
D	D	-	-	D	D	D
E	E	E	E	-	-	N
N	N	N	N	N	N	-
-	-	D	D	D	D	D
D	D	D	-	E	E	E
-	D	D	D	D	D	D

3rd Week

M	T	W	T	F	S	S
D	D	D	D	D	D	-
N	N	N	N	N	N	N
-	-	-	-	S	E	D
D	D	D	D	D	-	E
E	E	E	E	E	-	-
D	D	D	-	-	D	D

4th Week

M	T	W	T	F	S	S
-	-	D	D	D	D	D
N	N	N	N	N	N	-
D	D	-	-	D	D	D
E	E	E	E	-	-	N
-	D	D	D	D	D	D
D	D	D	-	E	E	E

5th Week

	M	T	W	T	F	S	S
"A"	D	D	D	D	D	-	E
"B"	-	-	-	-	S	E	D
"C"	D	D	D	D	D	D	-
"D"	N	N	N	N	N	N	N
"E"	D	-	-	D	D	D	D
"F"	E	E	E	E	E	-	-

6th Week

M	T	W	T	F	S	S
E	E	E	E	-	-	N
D	D	-	-	D	D	D
-	-	D	D	D	D	D
N	N	N	N	N	N	-
D	D	D	-	E	E	E
D	D	D	D	-	D	D

7th Week

M	T	W	T	F	S	S
N	N	N	N	N	N	N
D	D	D	D	D	D	-
D	D	D	D	D	-	E
-	-	-	-	S	E	D
E	E	E	E	E	-	-
D	D	D	-	-	D	D

8th Week

M	T	W	T	F	S	S
N	N	N	N	N	N	-
-	-	D	D	D	D	D
E	E	E	E	-	-	N
D	D	-	-	D	D	D
D	D	D	D	-	D	D
D	D	D	-	E	E	E

Legend — General Duty Schedule

1st	Week	Dec.	24	1956
2nd	"	"	31	
3rd	"	Jan.	7	1957
4th	"	"	14	
5th	"	"	21	
6th	"	"	28	
7th	"	Feb.	4	
8th	"	"	11	

1st	Week	Aug.	5	1957
2nd	"	"	12	
3rd	"	"	19	
4th	"	"	26	
5th	"	Sept.	2	
6th	"	"	9	
7th	"	"	16	
8th	"	"	23	

1st	Week	Mar.	17	1958
2nd	"	"	24	
3rd	"	"	31	
4th	"	Apr.	7	
5th	"	"	14	
6th	"	"	21	
7th	"	"	28	
8th	"	May	5	

1st	Week	Feb.	18
2nd	"	"	25
3rd	"	Mar.	4
4th	"	"	11
5th	"	"	18
6th	"	"	25
7th	"	Apr.	1
8th	"	"	8

1st	Week	Sept.	30
2nd	"	Oct.	7
3rd	"	"	14
4th	"	"	21
5th	"	"	28
6th	"	Nov.	4
7th	"	"	11
8th	"	"	18

1st	Week	May	12
2nd	"	"	19
3rd	"	"	26
4th	"	June	2
5th	"	"	9
6th	"	"	16
7th	"	"	23
8th	"	"	30

1st	Week	Apr.	15
2nd	"	"	22
3rd	"	"	29
4th	"	May	6
5th	"	"	13
6th	"	"	20
7th	"	"	27
8th	"	June	3

1st	Week	Nov.	25
2nd	"	Dec.	2
3rd	"	"	9
4th	"	"	16
5th	"	"	23
6th	"	"	30
7th	"	Jan.	6 1958
8th	"	"	13

1st	Week	July	1
2nd	"	"	8
3rd	"	"	15
4th	"	"	22
5th	"	"	29
6th	"	Aug.	5
7th	"	"	12
8th	"	"	19

1st	Week	June	10
2nd	"	"	17
3rd	"	"	24
4th	"	July	1
5th	"	"	8
6th	"	"	15
7th	"	"	22
8th	"	"	29

1st	Week	Jan.	20
2nd	"	"	27
3rd	"	Feb.	3
4th	"	"	10
5th	"	"	17
6th	"	"	24
7th	"	Mar.	3
8th	"	"	10

1st	Week	Aug.	26
2nd	"	Sept.	2
3rd	"	"	9
4th	"	"	16
5th	"	"	23
6th	"	"	30
7th	"	Oct.	1
8th	"	"	8

cided to pay 2½ days in lieu of statutory holidays, and to spread the payment over the year, so that in all, nine statutory holidays are allowed, 6½ in time and 2½ in salary.

Fourteen days off in eight weeks means 42 days on duty. With an 8-hour shift, each nurse works five and a quarter days or 42 hours a week.

On some of our wards we needed more day duty, but not extra evening or night shifts, so Sheet B was evolved. Nurses E and F do no night work, and all nurses do only one week evenings.

Needless to say there must be no changes in the routine and, if emergencies arise, outside temporary help must be obtained to fill the gaps.

The "legend" shows each nurse what shift, hours, time off, etc., she will have on any given date up to the end of September, 1958, and the dates are moved on after that time ad infinitum. For example if Nurse C wants to know what plans she can make for Easter week, 1958. Easter comes on March 31, the third week of her schedule. She will be off after a night term!

Scientists are speeding the production of a vaccine for a new type of influenza that has swept in epidemic form across much of the Far East. The epidemics are causing relatively few fatalities although hundreds of thousands of cases have been reported in Hong Kong, Malaya, Indonesia, Japan. Thailand, Formosa, India and the Philippines. A research doctor at the world influenza centre in London, England has been reported as saying that it is reasonable to guess that the disease will reach England, Europe and the United States this winter.

— *The Globe and Mail*

New Drugs and Drug Therapy

J. E. Halliday

As the tide of new drugs continues to advance and new products are introduced for use almost daily, one of the great problems confronting the members of the various health sciences is how to keep abreast of new developments in drug therapy. Any discussion of the very latest drugs would likely be out of date by the time it was completed. In this review, rather than attempt this, several drug classes will be surveyed briefly with regard to developments which have taken place within the last year or two. As a result, some of the information presented may not be considered new, but is presented as a basis for better appreciation of more recent developments.

Non-barbiturate Sedatives and Hypnotics

The barbiturates long have been the mainstay of the sedative and hypnotic group of drugs. The large number of barbiturates available, varying as they do in duration of action and in certain characteristics of pharmacological effects, give the physician a selection of agents for use in various situations where depression of the central nervous system is desired. Thus, we see some of them used for daytime sedation, for treatment of various types of insomnia and others for prevention of epileptic seizures or in psychoanalysis or for general anesthesia. While being extremely useful, the barbiturates have certain undesirable features which have resulted in accidental deaths of persons using them. In addition they have gained a somewhat unsavory reputation due to the frequency with which they are used for suicidal purposes and to the recognition that addiction can occur from their use.

Attempts to develop hypnotic and sedative drugs without the undesirable features associated with the barbiturates have led to the recent introduction of a number of compounds known as "non-barbiturate hypnotics." In general, these drugs are less potent than barbiturates and possess a wider margin of safety. Experience so far has shown that when used properly, under supervision, they are safe and reliable drugs. However, experience has also shown that some of these agents, at least in the hands of some persons, are capable of misuse with serious results. These agents are listed below with the brand-names in brackets. They are available for oral dosage only.

Methylparafynol (Dormison)	Capsules, 250 mg. & 500 mg. Liquid, 250 mg. per 4 cc.
Ethchlorovynol (Placidyl)	Capsules, 500 mg.
Glutethimide (Doriden)	Tablets, 250 & 500 mg.
Methyprylon (Noludar)	Tablets, 50 & 200 mg. Elixir, 50 mg. per tsp.
Ethinamate (Valmid)	Tablet, 500 mg.

In ordinary use, all are claimed to produce no hangover. Overdoses will produce marked central depression, but respiratory depression is not as serious as that produced by barbiturates. Occasional side-effects such as nausea and skin rashes have been reported with some of these drugs; methylparafynol may cause belching with an unpleasant aftertaste. Glutethimide and methyprylon act for about 5 to 8 hours; the others are shorter acting with a duration up to about 4 hours. These drugs appear to be filling a useful place in drug therapy but a wider experience will be necessary before a proper evaluation of their usefulness can be made.

Ataractic Drugs (Tranquilizers)

While the barbiturates will produce all degrees of central nervous system depression, from mild psychic sedation to complete anesthesia, the ataractic drugs, or ataraxics, are a new type of central depressant which

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acts in a more restricted manner on the central nervous system. The areas of the brain which are affected by these drugs lie below the cortex, hence consciousness is not dulled to any extent. In particular, the areas governing activity of the autonomic nervous system and those concerned with the outward expression of emotions are depressed. This particularly applies to chlorpromazine and Rauwolfia alkaloids such as reserpine. Other tranquilizers, such as meprobamate and phenaglycodal, depress reflex activity in the spinal cord with resultant relaxation of excessive skeletal muscle tone and muscle spasm. Still other drugs of this group act in other ways which are not well understood.

Clinically, the ataractic drugs differ from other central depressants in that they may:

1. Reduce or tone down a patient's anxiety and tension, with little or no dulling of mental function. Severe anxiety is often accompanied by symptoms resulting from autonomic instability and from inability to relax voluntary muscle. Hence the actions of these drugs may relieve these somatic symptoms as well as the disturbed emotional state.

2. Reduce psychomotor excitement in mentally ill patients without depression of mental facilities. Hence overactive, excited, assaultive patients may be quieted and made more cooperative and accessible for standard psychotherapeutic methods.

The areas of usefulness of the various tranquilizers therefore may be widely designated as: (a) in private practice for emotionally disturbed patients, and (b) in institutions for patients with mental diseases.

While they serve a useful purpose in office patients, the unrestricted use of tranquilizers by the general public is to be discouraged. They are certainly not to be taken for every trifling emotional upset. There is even considerable concern that the tranquilizing drugs have been overprescribed by physicians and psychiatric and medical associations have warned against this practice. It is possible that some patients have been maintained on tranquilizers when psychotherapy should have been indicated. In addition, some of these drugs are capable of producing serious side effects.

The number of ataractic agents available for use is continually increasing and only the better known ones will be briefly described here.

Chlorpromazine: This drug is known commercially as Largactil in Canada and as Thorazine in the U.S.A. It is a synthetic compound of the phenothiazine type, related chemically to the well-known antihistamine drug promethazine (Phenergan) which itself has some ataractic activity.

As an ataractic, chlorpromazine is of chief clinical importance in mental hospitals. Its other uses include the treatment of nausea and vomiting from various causes such as uremia, radiation sickness, various drugs and operational procedures. It is also useful for the treatment and prevention of shock and for potentiating the effects of analgesics and barbiturates.

Side effects may occur with chlorpromazine which with ordinary doses include mild hypotension, nasal congestion and dry mouth. With larger doses a more severe postural hypotension may be produced. Long continued treatment may cause jaundice which is due usually to stasis of bile in the bile passages, the viscosity of the bile apparently being increased by the drug. Usually no liver damage occurs. Symptoms similar to those of Parkinson's disease may also be produced, as well as skin rashes. Most serious side effect reported is in agranulocytosis, which is rare but of which fatal cases have occurred.

Pacatal; Sparine; Trilafon; Compazine: These are also phenothiazine compounds and therefore related chemically to chlorpromazine. Although there may be some variations they also, in general, resemble chlorpromazine in actions, uses and side effects.

Rauwolfia alkaloids — Reserpine: Reserpine, known commercially by various names including Serpasil, Sandril and Reserpoid, is the longest used and most widely studied of the Rauwolfia alkaloids. It is obtained from the root of Rauwolfia serpentina. Reserpine is of chief clinical importance in the treatment of institutionalized patients with mental disease. To some extent it is also used in treating non-psychotic emotional states in office patients and for the relief of certain

psychosomatic conditions, as for example, skin diseases in which there is a strong psychogenic factor. Reserpine is also somewhat widely used in the treatment of hypertension where it exerts a mild hypotensive action as well as its tranquilizing effect.

Side effects occur, of which minor ones include nasal stuffiness, lethargy, diarrhea and nightmares. More serious side reactions include a melancholic type of depression which occurs with continued use of the drug and which has been blamed for the suicide of patients under therapy with reserpine. Parkinsonian-like symptoms have also been reported while, with larger doses, increased gastric secretion may be produced. For the latter reason, reserpine is contraindicated where there is a history of hemorrhage from ulcer. It has been reported, however, that in small doses, reserpine has been used successfully as a tranquilizer in gastric ulcer patients as an adjunct to conventional ulcer therapy. The side effects of reserpine are more serious than initially thought and, as a result, dosage levels for continued treatment are reduced to what they were formerly. Reserpine is usually given orally but is also available for intramuscular or intravenous injection.

Other Rauwolfia alkaloids include *rescinnamine (Moderil)* and *deserpidine (Harmonyl)*. These possess similar actions to reserpine though claims for less severe side effects have been made.

Meprobamate: This synthetic compound is the tranquilizing drug which so far has been most used by the general public. It is available, generally on prescription only, under various trade names such as Equanil, Miltown, Tranquiline and Trelmar. Primarily, meprobamate is a muscle relaxant which acts by depression of central reflex centres. Its ataractic action is milder than that of chlorpromazine and reserpine and its chief clinical use is for the relief of anxiety and relaxation of associated body tensions in patients seen in office practice. Meprobamate is also a useful drug for relaxation of reflex muscle spasm such as that which occurs in some types of rheumatic diseases. It has also been reported to be of some value in controlling petit mal and psychomotor types of epileptic seizures.

Although meprobamate is a drug of relatively low toxicity, side effects have been observed. Drowsiness and minor allergic skin rashes and also more severe allergic reactions such as angioneurotic edema, bronchial spasms and purpura have been reported. The impression has been gained by some physicians that habit formation, with psychological and even physical dependence, is possible in some persons if this drug is made freely available to them. Meprobamate is taken orally, and is available in 400 mg. tablets.

Phenaglycodal: This agent is related chemically to meprobamate and has similar actions and uses. In Canada it is distributed under the name of Acalo, and in the United States as Ultran, in capsules of 300 mg.

Miscellaneous ataractic drugs: Azacyclonal is known commercially as Frenquel, and differs in its action from other tranquilizers, being said to have the ability to block hallucinations resulting from mental disease and other causes. It is used in institutions and the results reported have not always been consistent.

Hydroxazine is known as Atarax and is recommended for treating emotionally disturbed office patients.

Benactyzine is sold as Levol or Actozine in Canada. It also is used for office patients, said to be particularly useful in anxiety due to environmental stress.

Captodiamin, or Suvren, is another drug whose use is chiefly in office patients for treatment for less severe anxiety states.

Mood Elevators and Appetite Depressants

In addition to the new central depressant drugs, just discussed, there have also been some recent developments in the field of central stimulants. The familiar drugs of the amphetamine group, amphetamine (Benzadrine), dexamphetamine (Dexedrine) and metamphetamine (Desoxyn, Methedrine, etc.), have been in use for some years. Because of their ability to relieve mental depression and produce a state of energetic wakefulness, they have earned the description of "mood elevators." These agents also

possess an actual depressing effect on appetite, and this action, together with the mood elevating effect, has made them useful adjuncts to diet and other measures in the treatment of obesity. Amphetamines must be used with care and supervision. If used indiscriminately to maintain a state of wakefulness, proper rest may be neglected and collapse may follow. They have the disadvantage that the stimulant action is often followed by a sense of depression and fatigue, and furthermore, due to their constricting effect on blood vessels they tend to cause an increase in blood pressure. It should also be mentioned that addiction has occurred to these drugs.

Fairly recently three new drugs have been introduced which are used for similar purposes to the amphetamines but in which some of the disadvantages of the amphetamines appear to be overcome.

Pipradol (Meratran) and *Methylphenidate* (Ritalin) are said to produce their mood elevating effect without causing depression of appetite and with no effect on blood pressure. These agents are used to overcome depression and fatigue due to various causes and may be used in some cases where amphetamines are contraindicated. They have also been used to overcome undesirable depressant effects of other drugs. For example, methylphenidate has been combined with reserpine to offset the mental depression that may follow the use of the latter drug.

Phenmetrazine, known also as *Preludin,* is a drug with appetite-depressing action but with little central stimulant action. It is used to curb the appetite of people on diets, but like the other new drugs in this group it has not been in use for long enough to allow a proper evaluation. It is not entirely without stimulating effects and though side effects appear to be minimal, the occasional person has complained of feeling sad or blue while taking this drug.

Newer Corticosteroids

The term corticosteroids is used to designate the steroid hormonal substances obtained from the cortex of the adrenal gland, and their derivatives. The use of the older members of this group, cortisone and hydrocortisone, in the therapy of a wide variety of rheumatic, inflammatory and allergic conditions has been well established for several years. Since successful therapy of diseases not related to adrenocortical deficiency requires the presence in the body of larger than normal amounts of these hormones, side effects occur which present a serious drawback to prolonged therapy with these drugs. Among these unwanted effects are increased retention of salt and water leading to edema, aggravation of peptic ulcer, elevation of blood pressure, facial rounding and other deposits of body fat, acne and increased growth of body hair. Developments within the last year or so have resulted in a greater variety of corticosteroids being made available, some having distinct advantages insofar as the incidence of certain of the side effects is concerned.

Prednisone (Meticorten; Colisone; Deltra) which is derived from cortisone, and *Prednisolone* (Metacortelone; Sterane; etc.) a derivative of hydrocortisone, have been in use for about two years. These drugs are from three to five times as potent as their parent compounds in anti-inflammatory and anti-rheumatic activity but are less likely to produce the side effects of salt and water retention and elevation of blood pressure. Apparently, however, the tendency to cause gastric irritation and to aggravate ulcers is not appreciably reduced. This has led to the production of products in which the steroid is combined with a gastric antacid, as for example, in Co-Hydeltra.

Fludrocortisone Acetate, known commercially as Aflorone, is much more potent than the older corticosteroids, but this potency also extends to the side effects, particularly those affecting salt and water metabolism. Its use therefore is restricted to topical application, and even when used in this way, in dermatological conditions, edema has been caused through absorption of small amounts into the system.

Combinations with salicylates are another rather recent innovation in the field of corticosteroid therapy. These consist of tablets in which a corticosteroid is combined with either sodium salicylate or acetylsalicylic acid

(aspirin) and were introduced following the discovery in long-term controlled trials that salicylates were as effective as cortisone in controlling the symptoms of early rheumatoid arthritis. Examples of this type of preparation are: Salcort (cortisone acetate combined with sodium salicylate); Sigmagen (prednisone combined with acetylsalicylic acid) and Cordex (prednisolone combined with acetylsalicylic acid). These combinations are effective in many cases of rheumatoid arthritis and have the advantage that the dose of the steroid is much below that which would be required if it were the only medication being taken. Hence side effects can often be avoided.

Medrol is the brand name for still another new hydrocortisone derivative which is many times more potent in its activity than cortisone and hydrocortisone but without a similar increase in effects on salt and water balance. Although it is too new to permit a proper evaluation, this drug promises to be another valuable addition to the agents available for corticosteroid therapy.

Other recent developments include forms of hydrocortisone better suited for local application and products combining corticosteroids with other medicaments intended for local use such as antibiotics and nasal decongestants. Corticosteroids are also used now combined with ataraxics; examples of such preparations are Meprolone, combining prednisolone and meprobamate, and Ataraxoid, combining prednisolone and atarax, which are intended to relieve both the physical symptoms of rheumatic disease and the emotional strains which may accompany it.

Newer Developments in Antibiotics

Antibiotics continue to be one of the most active fields of drug research, not only in regard to the search for new antibiotics, but in seeking improvements in the older drugs.

Benzathine Penicillin G (Bicillin; Permapen; Duapen). This long-acting form of penicillin, though not exactly new, has become recognized in recent years as the most useful form for use in prophylaxis of rheumatic fever. Since administration may require continuation for as long as five years or longer, the prolonged duration of action of Benzathine penicillin is of value in that injections need be given only once monthly in children. The monthly intramuscular dose is 1,200,000 units.

Phenoxymethyl Penicillin (Penicillin V) — Known commercially as V-Cillin; Pen-Vee-oral, etc., this is a form of penicillin which is much more effective when given by mouth than penicillin G. Since it is more stable in the acid medium of the stomach, greater amounts are absorbed and thus higher and more prolonged blood levels may be reached than with older oral forms of penicillin.

Tetracycline Sodium Phosphate mixture — Tetracycline (Achromycin, Panmycin, Tetracyn, etc.) is probably the most frequently used of the broad spectrum antibiotics, but has a disadvantage in that absorption from the intestinal tract, though sufficient to produce adequate blood levels, is not complete, a factor which may lead to such side effects as moniliasis. A recent preparation, Achromycin V, contains a mixture of tetracycline and sodium metaphosphate from which the absorption of the antibiotic is enhanced, resulting in higher and faster blood levels.

Newer Antibiotics:

Novobiocin (Cathomycin, Albamycin, Cardelmycin) has a similar antibiotic spectrum to penicillin and may be used effectively in certain infections with organisms which are resistant to penicillin and other antibiotics. However, bacteria, particularly staphylococci, will also develop resistance to novobiocin.

Oleandomycin (Matromycin, Romicil) is of clinical value in the treatment of the same types of infections which respond to penicillin and erythromycin. It may be of importance where organisms have developed resistance to the latter two antibiotics. Initial reports indicate that resistance develops slowly to oleandomycin.

Cycloserine (Seromycin, Oxamycin) is a broad spectrum antibiotic whose greatest value so far has been in the treatment of tuberculosis. Large doses appear to have a toxic effect on the

central nervous system causing convulsions. These have disappeared when dosage was reduced.

Antibiotic Combinations:

There have been introduced recently, preparations containing two antibiotics combined in a single capsule. Examples of these are Sigmamycin, containing tetracycline and oleandomycin, and Cathocillin, containing novobiocin and penicillin. Among the possible advantages of such combinations are synergism between the two drugs, increase in range of activity and delay in emergence of resistant organisms. While it is recognized that in certain cases the combining of antibiotics may produce results superior to those obtained with single antibiotics, there is considerable opinion against the encouragement of the use of these ready-made or "fixed" combinations. Instead, it is argued, the decision as to which antibiotics to combine, and in what dosage they should be given, should be made by the physician for each individual case. It will be some time before it can be determined how useful and how popular these combinations will become.

SUMMARY

This review has dealt briefly with only a few of the newer drugs; one could go on almost indefinitely without mentioning them all. In recent months there have been introduced, Kynex, a new long-acting sulphonamide; tolbutamide, an orally-active hypoglycemic agent for use in diabetes, available in Canada as Mobenol and Orinase; and to the drugs for treating hypertension, there has been added a new ganglionic-blocking agent called Inversine that is completely absorbed from the intestine. The drugs of today are more potent, more specific and more effective than ever before. While they are achieving greater result in the alleviation of disease, they also require more care in their handling and greater individualization of dosage than the older drugs. Since they are being discovered at a more rapid rate than ever before, it requires constant reading and studying on the part of those associated with their use and administration in order to keep abreast of modern developments in this most rapidly advancing field.

In the Good Old Days

(*The Canadian Nurse* — OCTOBER, 1917)

It is a sign of the times that the National Council of Women, at their meeting in Winnipeg, brought in as one of their resolutions the need for universal Dominion Registration of nurses.

* * *

A Spanish medical journal recommends the use of the fumes of iodine in chronic cystitis. As iodoform is heated over an alcohol flame, the fumes are pumped through a catheter into the bladder.

* * *

A baby clinic to treat children from the time of birth to six years of age is to be established at the city health office in Victoria.

A Provincial Association of Graduate Nurses was recently formed in Quebec.

* * *

Formely, and in fact only till recent years, it was considered that the nation with the highest infant mortality was the most fortunate. It is barely forty years since the new interest in the lives of infants became manifest.

* * *

When painful feet are complained of in pregnancy they should be strapped at once. A suitable shoe should be provided and proper exercises prescribed. The toes should be trained to grasp a small rubber ball, like a ping-pong ball.

There is no good arguing with the inevitable. The only argument available with an east wind is to put on your overcoat.

—James Russell Lowell.

Suggestion for a hospital accident prevention poster: Don't get hurt. We are here to take care of accidents; not to produce them.

The Ward Book

MARGARET FERGUSON

ANY SYSTEM THAT will simplify ward charting procedure, be effective and safe, yet less cumbersome is welcomed in any progressive hospital. In an effort to achieve such an improvement, one of the services at the Victoria General Hospital has experimented with a "Ward Book System" which appears to fulfill these requirements.

The Ward Book consists of a leather-bound loose-leaf with alphabetically arranged divisions. For each patient there is on the left a blue doctor's Order Sheet, on the right a white Nurses' Charting and Report Sheet. The latter is divided vertically into two parts, with the left half showing the medication plan, and the right the daily progress notes and report. At the top left of this sheet the diagnosis and operation (if any) are written in so that the nurse, interne, or resident can recall at a glance the clinical situation they are handling. (This has also proved helpful to the attending staff.) At the top right is the patient's name, address, admission date, etc.

The doctor's Order Sheet and the nurses' Charting and Report Sheet are part of the patient's permanent record but are kept in the Ward Book while she is in hospital, and then attached to her permanent record on discharge. In the case of patients undergoing surgery the doctors' Order Sheet goes to the operating room and recovery room with her record, but is replaced in the Ward Book on her return. The nurses' Charting and Report Sheet does not go to the operating room as we have a special Recovery Sheet. On the front cover of the book is loosely clipped a plain sheet, renewed daily. (See Fig. 1)

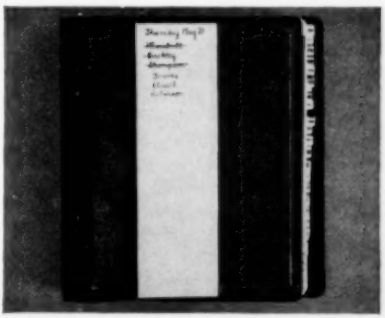
The simple procedure used is as follows:

(a) When an order is written by the doctor on the blue Order Sheet, he also writes the patient's name on the plain sheet on the cover, thus indicating to the nursing staff that an order has been written. (See Fig. 2). When the nurse is thus made aware of the order she draws a line through the name.

(b) *The medication plan:* Having noted the doctor's order, the charge nurse sets out the medication plan which indicates the day, dose and times of administration. The nurse giving the medication initials over the appropriate time entry.

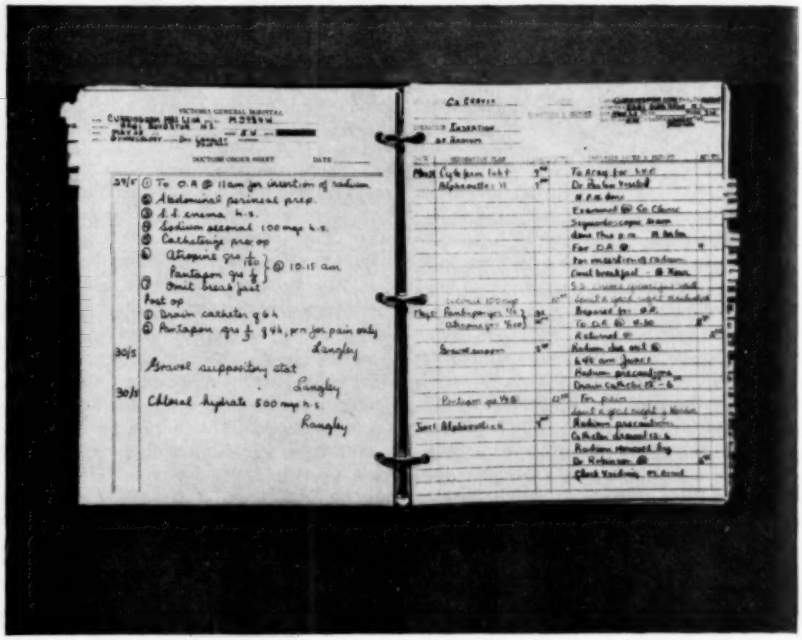
(c) *The progress notes and report:* Using blue ink for the day, red for the night, any specific treatments given, brief notes on patient's progress, orders for procedures to be carried out, etc., are indicated. (For particular emphasis, special items may be indicated in the reverse color or underlined.) Such duties as pre- or postoperative orders, change of dressings, catheterizations, alterations in patient's condition, etc. are noted on this portion of the sheet. If, in the case of a patient remaining a long time in hospital, the number of these sheets becomes excessive, the earliest are transferred to the patient's chart to keep the Ward Book from becoming too bulky.

By using this system, none of the usual safeguards have been lost. Indeed, our experience suggests there is additional safety in that we have consolidation, less duplication and copy-



The Ward Book

Miss Ferguson is in the department of gynecology at Victoria General Hospital, Halifax, N.S.



Sample pages

ing, and notes are more concise and informative.

The general benefits derived from this system affect all members of our team: (a) the medical staff: (b) the graduate nurses; (c) the student nurses; (d) the patients and ward.

The Medical Staff: On ward rounds the attending doctors benefit because (a) the book is carried around by the interne, resident or nurse, and all orders and nurses' notes are immediately available, including the diagnosis of the case, any operation that was done, and the date of the operation.

(b) It is possible to see at a glance on the opposite page what medications have been given and what orders have been carried out, without wasting time leafing through the chart.

(c) The Ward Book being so easily portable, any orders for the patient may be written during rounds, instead of the doctor trying to remember them on his return to the desk or having to make notes on a pad that later have to be transferred to the Order Sheet.

The Head Nurse: Since the charge nurse carries the responsibility for the total patient care the entire 24-hour period, the Ward Book is especially helpful to her because she is relieved of the necessity of going through from 20 to 35 charts four or five times a day in order to do her charting or watch her orders. She has only to go through our Ward Book which lies continually on her desk. She is thus less apt to be chained to her desk. Its chief value to her is the time saved and the convenience of having the doctors' Order Sheet and nurses' sheet of all her patients immediately under her hand. The Kardex, with its added sheets to be filled in and kept up to date, is eliminated. It is no longer necessary to look through every chart searching for orders which may have been written much earlier. The head nurse is set free to be present *at the bedside.*

The students benefit from more clinical supervision, closer patient-nurse relationship.

Change of shift and report: When giving a detailed report, at the shift changes, it is very simple to discuss each patient from the Ward Book. The night nurse finds it particularly useful,

since it saves her a tremendous amount of time in looking for orders and in charting.

We have found this method to be most efficient, accurate and time-saving for all who are concerned with the immediate care of the patient. It seems to eliminate, as no other system we have used, the possibility of mistakes and particularly of overlooking orders.

One Candle on the Cake

ALBERT W. WEDGERY, R.N.

BIRTHDAYS, WHILE NORMALLY regarded as occasions for celebrating the inexorable passing of time, are often looked upon as annual milestones, thereby serving as vantage points from which events of the preceding year can be considered in retrospect. Now that the Male Nurses' Committee of the Registered Nurses' Association of Ontario has weathered successfully its first year of existence, the initial anniversary of its formation may well be the appropriate opportunity to reflect on its accomplishments. Moreover, some evaluation of its efforts is in order if for no other reason than to determine, because of its unique character, whether it has a definite contribution to make to the progress of nursing in Canada.

It will be recalled that the Male Nurses' Committee of the R.N.A.O. came into being in April 1956 to deal with the special problems of professional recognition and advancement confronting the growing number of male nurses who are seeking employment in Ontario. Although several matters peculiar to male nurses have come before the Committee for discussion during the past year, its general purpose has been to act as the authorized group representing approximately 120 male nurses now registered in this province. Already in nursing circles across Canada there has been a gradual awareness of the work of this enthusiastic group of men and an increasing realization that at last an almost forgotten and silent section of the nursing profession has found an official and articulate voice for its problems.

No group can function adequately nor proceed far without setting for itself some precise objectives that will give purpose to its activities. The Males Nurses' Committee, fully conscious that its efforts would be watched with critical interest by leaders of the profession, has been guided by the following terms of reference:

1. To interpret to the profession and to the public the place of the male nurse in the profession and in the community.
2. To maintain contact with all male registered nurses within the province, and to promote membership in the Registered Nurses' Association of Ontario.
3. To encourage all male members to participate in the affairs of the Association at provincial, district, and chapter levels.
4. To promote recruitment of young men into the profession.

It will be observed that, although these specific aims pertain to matters affecting male nurses, they are sufficiently broad in scope to serve the best interests of the entire profession.

The greater part of this past year was devoted to a consideration of professional identification, a problem that appeared at first examination to be restricted solely to male nurses who, due to similarity of uniform, are more often than not confused with interns and orderlies. When discussion of a standard uniform for male nurses uncovered a wide diversity of opinion even among such a small number, it was decided to abandon this phase of inquiry as inadvisable and impractical. However, when this investigation elicited the information that female nurses often lack immediate recognition when encountered in the midst of other hospital personnel who are similarly dressed, the committee undertook to make a study of the whole subject.

Accordingly, at the 1957 annual meeting of the Registered Nurses' Association of

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Mr. Wedgery is supervisor of the operating room at the Oshawa General Hospital, Oshawa, Ont. He is chairman of the Committee whose work he discusses.

Ontario, it was the privilege of the Male Nurses' Committee to present a report on the identification of the professional nurse. Dealing with the problem under the headings: uniforms, caps, and pins, it was clearly demonstrated that the nursing profession is no longer positively identified either to the patient or to the public. In other words, it lacks a distinctive professional individuality that sets it apart from the ever-growing numbers of non-professional workers now engaged in the care of the sick. This report, which was adopted by the general membership of the Association, concluded with the recommendation that all professional nurses should wear some unequivocal mark of identification that can be easily and readily distinguished.

During the coming year the Male Nurses' Committee will turn its attention to a study of ways and means of recruiting men into nursing. Viewed in the light of the present unabating shortage of nurses, the attraction of more young men into the profession may be one inevitable step to meet the increased demands that will be placed on nursing service everywhere by the inception of a scheme of national health insurance. Every person within the profession who is genuinely interested in the training of more male nurses should take heart from the following words of Dr. W. Ross Wright, which appeared in his article, "A Doctor Looks At Nursing," in the February, 1957, issue of *The Canadian Nurse:*

> There is also a place for men in nursing — not as glorified orderlies, but as well-educated men who will give leadership and fill responsible positions in teaching and administration. Once a living wage is established whereby a man may choose nursing as a lifetime career, then we may once again hope to have positions filled for years instead of months. With the acute shortage of nursing personnel in our mental institutions, there are now many opportunities for employment of male nurses in this field.

After this frank appraisal of the situation with regard to the need of more men within its ranks, the nursing profession would do well to explore the vast potential existing in the male population of this country by creating incentives and personal rewards that will cause young men to give serious consideration to nursing as a respectable and satisfying vocation.

The degree of success achieved by the Male Nurses' Committee by the end of its first year of activity has more than justified the belief of its members that it is blazing a new and much-needed pathway through certain neglected areas of nursing. Particularly, it is hoped that in those provinces outside Ontario where male nurses are working in sufficient numbers, the efforts of this little band of able men will encourage the formation or similar groups under the auspices of other provincial nursing organizations. Furthermore, if more male nurses in Ontario, and elsewhere in Canada, can be stimulated to join, support, and take an active part in the affairs of their provincial and national nursing associations, the committee will have realized its main purpose.

In these days of far-reaching changes within the profession, nursing needs men to share in its activities, to shape its policies, and to give required direction in its progress toward full professional status. The Male Nurses' Committee of the R.N.A.O. ever mindful of its responsibilities as the standard-bearer in the advance toward a brighter future for men in nursing, is ready and eager to lead the way.

Successful treatment of gangrene of the feet and legs by letting the patient walk — a reversal of the usual procedure of confining the patient to bed — has been reported . . . Amputations were avoided and the gangrenous condition healed in 21 out of 22 cases when patients were encouraged to get out of bed and walk despite their ailment. The one failure occurred in the case of a woman whose family felt it was cruel to make her walk on her gangrenous toes.

The gangrene was a complication of various circulatory diseases that had cut down the flow of blood to the feet or legs. When such patients are kept in bed, blood flow decreases even more with resulting atrophy and wasting of muscle tissue . . . Because it has long been known that walking is one of the greatest stimuli to improved circulation in the legs, it was decided to try it as a treatment for gangrene.

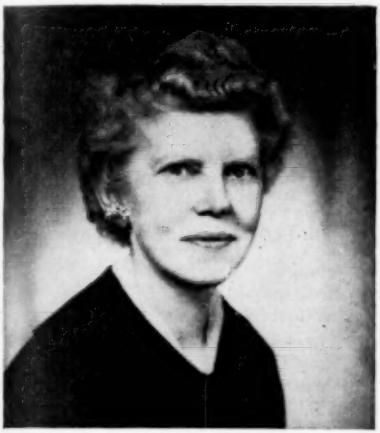
Other aspects of care include the treatment and prevention of local infection and strict prohibition of tobacco because of the long-established constricting effect of nicotine on the blood vessels of the legs.

— American Heart Association

The wrong way always seems most reasonable. —George Moore

Nursing Profiles

Agnes Ohlson, the president of the American Nurses' Association since 1954, has been elected president of the International Council of Nurses for the period 1957-61.



AGNES OHLSON

A graduate of the Peter Bent Brigham Hospital School of Nursing, Boston, Mass., Miss Ohlson received her Bachelor of Science degree from Teachers College, Columbia University and a Master of Arts degree from Trinity College, Hartford, Conn. Her experience in the profession of nursing has been broad including both the educational and service branches. Beginning as a supervisor at the Wesson Maternity Hospital, Springfield, Mass., Miss Ohlson subsequently filled the position of assistant superintendent of nurses at Truesdale Hospital, Fall River, Mass. and of director of nursing service and of the school of nursing at Waterbury Hospital, Conn.

During World War II she served as nursing consultant for the United States Cadet Nurse Corps. She is the president of the American Nurses' Foundation, Inc. established by the ANA in 1955. This foundation conducts research projects throughout the country as one step toward improving nursing practice and nursing education. At the present time Miss Ohlson is the Chief Examiner for the Connecticut Board of Examiners for nursing which licenses professional and practical nurses and accredits programs of schools of nursing in the state. Her wealth of experience and knowledge of nursing affairs have made her a popular member of various state and national committees, and have drawn her into international affairs.

The International Council of Nurses anticipates a period of constructive work and progress under her direction.

Frances G. Goodall who, for nearly 30 years, has been the General Secretary of the Royal College of Nursing, London, England has relinquished this post and is devoting her time in part to her duties as Chairman of the Staff Side of the Nurses and Midwives Whitley Council.

In her years of service with the College Miss Goodall has been closely connected with developments that have greatly raised the status of nursing. The shaping of nursing policy has been one of her major concerns. Her work with the Athlone Committee during which time she prepared evidence on the education, training and remuneration of nurses in Britain and later with the Rushcliffe Committee that formulated the first national scale of nurses' salaries are outstanding examples. Her belief and interest in joint negotiation and consultation prompted the College to support the development of a Whitley Council for Nurses and Midwives when England's National Health Service was instituted. Miss Goodall became the first nurse chairman of this Council in 1956.

In recognition of her public service she was made a Commander of the British Empire in 1953. Her portrait by James Gunn, A.R.A. was presented to the College in 1955 and later was hung in the Royal Academy of Arts Summer Exhibition, 1956. Colleagues and friends are happy to think that she will now have more time to devote to her many other interests.

Catherine M. Hall, the former assistant matron of Middlesex Hospital, London England has succeeded Miss Goodall as General Secretary. Miss Hall obtained her training at the General Infirmary and the Maternity Hospital, Leeds and at Moorgate General Hospital, Rotherham. She was the first holder of the travelling fellowship for study abroad awarded by the United Leeds Hospitals, spending her time in

Canada and the United States. Later a scholarship awarded by the Joint Committee of the Order of St. John and the British Red Cross resulted in study at the Royal College of Nursing where she excelled in all subjects in the nursing administration course.

Sister Mance Décary is the director of nursing at Notre Dame Hospital, Montreal. A native of Quebec, Sister Décary received the major part of her academic and professional training within the province. She is a graduate of the school that she now directs.

She obtained the degree of Bachelor of Science of Nursing from l'Institut Marguerite d'Youville in 1938 and has taken special study in public speaking, philosophy, English and French literature at the University of Montreal and Rutgers University, New Jersey. She has participated in various other professional courses held at American universities. Her administrative ability has been put to good use many times, first as director of her school of nursing 1938-45 — a position to which she returned in 1951 after four years as assistant administrator at l'Hôpital St. Pierre in New Brunswick, and two years as assistant to the Director General of her religious community. Committee work within the hospital and at provincial and national levels has claimed and continues to claim her enthusiastic support. Her most recent appointment was to the Committee on Public Relations of the CNA and she attended the ICN congress in Rome as an official national delegate.

With her background of experience and her keen mind, it is quite natural that research in nursing should be one of her greatest interests. Her devotion to her profession has extended even into her leisure time which is often spent in teaching at Institut Marguerite d'Youville, the University of Montreal or in writing. Sister Décary was made a Member of the British Empire in 1943.

Janie F. M. Church became the new director of nursing at Victoria Hospital, Renfrew, Ont. recently. After obtaining her Bachelor of Arts degree from the University of Toronto, Miss Church began her professional training at the Royal Victoria Hospital, Montreal graduating in 1943. In 1944 she joined the R.C.A.M.C. and spent the succeeding 18 months in military service in Canada and England.

JANIE F. M. CHURCH

After her return from overseas she spent some time as an operating room nurse at the Great War Memorial Hospital, Perth, Ont. before returning to the University of Toronto for postgraduate preparation in clinical supervision. She comes to her new position from Langley Memorial Hospital, Murrayville, B.C. where she has been for the past eight years.

SISTER M. DECARY

There is no duty we underrate so much as the duty of being happy. — *R. L. Stevenson.*

RESEARCH

Recherche en Nursing à l'Hôpital Notre-Dame

Soeur Mance Décary, s.g.m., B.Sc. *et* Jacqueline Ouimet, B.Sc.

La recherche en administration du nursing dans un hôpital, consiste en une investigation scientifique du travail accompli par toutes les catégories du personnel du nursing, des techniques employées et des problèmes qui se posent dans les soins que nous prodiguons aux malades.

Le but de ce projet est l'élaboration d'un plan en vue d'améliorer le soin des malades en utilisant au maximum les connaissances et les talents respectifs de chaque membre du personnel professionnel et non-professionnel, et ainsi de rendre justice à tous. Les raisons qui nous ont incité à croire qu'une étude des tâches s'imposait pour toutes les catégories de notre personnel du nursing, sont les suivantes:

1. La complexité du service, vu les changements fréquents dans les techniques de diagnostic et de traitement selon les progrès de la science médicale. Les médecins se voient obligés de déléguer une partie de leurs attributions aux infirmières licenciées. Il s'ensuit que celles-ci doivent confier quelques-unes de leurs tâches à un personnel auxiliaire.
2. La création de nombreuses spécialités.
3. L'exiguïté des locaux, qui occasionne des transferts fréquents et apporte un surcroît de travail au personnel du nursing.
4. Les difficultés provenant du manque de facilités physiques, v.g.: lenteur des ascenseurs, roulement du personnel, accroissement constant du travail de bureau, etc.
5. Les changements considérables dans l'organisation des départements dus à la décentralisation d'une part, et à la centralisation d'autre part: ainsi jadis dans un département, tout le travail était centralisé sous l'autorité de l'hospitalière. Aujourd'hui, l'hospitalière accomplit un travail de coordination avec les autres services extérieurs au département: Centre de Stérilisation, Centre de Pansements, Service d'Alimentation, Service d'Entretien et même Service des Messagers.
6. L'agrandissement qui sera bientôt une réalisation.

Un projet de cette envergure ne pouvait se réaliser qu'avec l'approbation des autorités de l'hôpital, le concours généreux du Ministère de la Santé de la Province de Québec, du Service des Recherches du Ministère de la Santé nationale et du Bien-Etre social d'Ottawa. Tout le travail s'est accompli sous la direction de M. J. W. Willard, Directeur de la Division de Recherches, de M. Gordon Josie, Surveillant de la section des Méthodes et des Analyses et de M. Charles B. Walker du même service.

L'observation elle-même a été précédée d'un questionnaire intitulé "Études sur les attributions quant aux fonctions à remplir dans le nursing." Nous avons distribué 950 questionnaires à tout le personnel médical, professionnel et non-professionnel de l'hôpital; 549 nous furent retournés avec un total de 165,000 réponses à codifier.

Sur recommandation des autorités, nous avons choisi quatre observatrices parmi le personnel de notre hôpital, afin que dans la suite, elles puissent jouer le rôle de consultantes. Nous leur avons aussi adjoint un professeur

Soeur Décary est Directrice du Nursing, Mlle Ouimet, Assistante-Directrice du Nursing, à l'Hôpital Notre-Dame, Montréal.

de l'Institut Marguerite d'Youville, experte en matière d'éducation. Ces cinq observatrices étaient: Soeurs Jeanne Forest et Annette Rose, et Mesdemoiselles J. Ouimet, E. Bernier, et P. Roy.

Au début du mois d'août 1956, une lettre officielle envoyée à tous les membres du personnel de l'hôpital annonçait le début de notre projet d'étude. Les détails furent expliqués de vive voix en assemblées.

Après une année de préparation, nous sommes enfin arrivés à la période d'observation. Du 27 août 1956 au 8 septembre 1956, de 7:30 heures a.m. à 7:30 heures p.m., quatre cents périodes d'observations d'une demi-heure chacune furent effectuées dans quatorze unités de nursing, excluant les cliniques, salles d'opérations et le service central. Personnes observées dans huit catégories du personnel:

Hospitalières et assistantes-hospitalières	— 130	périodes
Infirmières licenciées	— 40	périodes
Etudiantes	— 110	"
Auxiliaires en nursing	— 20	"
Aides-malades	— 30	"
Réceptionnistes	— 40	"
Infirmiers	— 30	"

Chaque observatrice a couvert un total de 80 périodes d'observations au rythme de 7 à 10 par jour, avec minutage au chronomètre des activités.

Les détails enregistrés étaient: l'action posée, sa nature, la personne observée, les lieux, les procédés et le matériel employés, le temps consacré à chacune des activités. Plus de 300 personnes participèrent à l'étude avec une franche collaboration et un enthousiasme évident.

Soixante-sept analyses devront ressortir de cette étude. Le résultat nous servira de guide dans l'organisation du travail d'équipe. L'analyse des tâches nous aidera:

à utiliser au maximum les talents individuels dans la redistribution du travail;

à définir la proposition entre le personnel professionnel et non-professionnel;

à étudier les méthodes simplifiées et standardisées de travail;

à établir les méthodes d'éducation pour tout le personnel par un programme explicitement défini.

Une fois la période d'observation terminée, plusieurs mois s'écouleront sûrement avant la publication du rapport complet. A date, la codification de près de 13,428 activités est finie. Pour l'analyse des 460,000 item de nos rapports, il a fallu recourir à un système de cartes, type Underwood Samas, tel que préconisé par nos consultantes. Le travail de transcription qui se fait ici même exige une précision minutieuse et une ténacité inlassable. Dans un avenir très prochain, nous pourrons passer à l'analyse et à l'évaluation de ces données pour enfin en tirer les conclusions.

Trois membres de notre personnel ayant fait un stage au nursing au Teacher's College, Columbia University, New-York, afin d'étudier le travail d'équipe et de nous seconder efficacement dans notre travail de réorganisation, il nous fut donc possible dès le début d'octobre, de commencer l'organisation du travail d'équipe. L'enseignement individuel détaillé de ce mode de travail a été donné à trois unités de nursing, et un enseignement collectif résumé a été exposé devant près de 350 personnes en six séances différentes. Les résultats à date sont satisfaisants, et nous nous proposons d'établir cette technique dans tout l'hôpital à l'occasion des vacances d'été.

Nous avons aussi résolu d'étudier le détail de l'observation faite durant une semaine sur 139 malades du service de médecine, qui ont reçu en 24 heures, une moyenne de 13.51 médicaments et traitements, ceci à l'exclusion des soins hygiéniques et des diètes, soit:

255 médicaments liquides
644 médicaments (pilules)
38 injections intra-veineuses
125 injections intra-musculaires
137 tensions artérielles
46 solutés
4 transfusions
6 ponctions lombaires et paracenthèses
29 aérosols
25 oxygène
18 aspirations de sécrétions
26 radiographies
28 analyses
57 dosages
318 prises de températures
12 pansements
12 lavements
14 cathétérismes
22 suppositoires

21 malades pesés
31 traitements divers

Des études similaires faites aux Etats-Unis démontrent qu'un minimum de 3.4 au maximum de 8.1 médicaments et traitements sont donnés aux malades en 24 heures. Devant ces faits éloquents, nous avons cru bon, au lendemain de notre travail de recherche, de présenter ce rapport à une réunion du Comité Conjoint du Nursing, composé de médecins et d'infirmières. Il fut alors proposé et adopté à l'unanimité de recommander à l'Exécutif du Bureau médical, la formation d'un comité temporaire pour étudier la possibilité de diminuer les traitements et de simplifier certaines routines dans le soin des malades.

Le Comité Exécutif du Bureau médical approuva cette proposition et nomma pour cette étude les médecins siégeant actuellement au Comité Conjoint du Nursing. Il fut décidé à une réunion subséquente de demander l'aide du Comité d'études des Techniques et pratiques. Ce comité est composé de la Directrice du Nursing, de la Coordinatrice des Etudes, de la Directrice du Nursing en Education, de surveillantes, d'hospitalières, d'institutrices. Après une longue et sérieuse étude, on fit les suggestions suivantes:

1. *Tension artérielle:* A l'unanimité, il est connu que les tensions artérielles sont demandées plus fréquemment par les internes que par les médecins professeurs, soit quatre fois par jour, aux heures et même aux dix minutes, et souvent les médecins oublient de discontinuer ou de modifier cette prescription. On est d'avis que la prise de la tension artérielle aux dix minutes exige le service d'une infirmière spéciale. On suggère de fixer une limite de 4 à 6 heures pour les tensions artérielles prescrites aux heures. Si un chef de service trouve son malade dans un état qui nécessite la prise de tension artérielle aux heures, jour et nuit, il est suggéré que l'interne assume cette responsabilité.

Afin de démontrer l'importance de cette demande, une étude de certains dossiers a été faite au point de vue de la fréquence de la prise des tensions artérielles. Afin de laisser aux médecins le bénéfice de poser des conclusions pratiques, énumérons quelques exemples:

(a) Mme A. Diagnostic: obésité — kyste du sein. T.A. à l'arrivée: 148/110 — aucune médication agissant sur la T.A.

Prise de la T.A. prescrite aux heures:

1 hre p.m. — *2 hres p.m.* — *3 hres p.m.*
145/85 145/80 140/70
4 hres p.m. — *5 hres p.m.* — *6 hres p.m.*
120/70 150/70 135/70
prescription non cessée.

(b) M. X. Diagnostic: rhino-plastie T.A. à l'arrivée: 120/80

Après anesthésie — prise de la T.A. prescrite aux heures:

2 hres p.m. — *3 hres p.m.* — *4 hres p.m.*
125/70 120/75 125/70
5 hres p.m. — *6 hres p.m.*
115/70 120/75 prescription non cessée.

(Tensions prises au lit du malade après son arrivée de la salle de réveil.)

2. *Température:* Il est proposé d'étudier la possibilité d'omettre la prise de température du matin pour les patients ne faisant pas d'hyperthermie. La température serait prise deux fois le premier jour d'hospitalisation, et ensuite, une seule fois par jour, à moins qu'il n'y ait hyperthermie ou une prescription spéciale du médecin. Quant à la température à prendre aux deux heures et aux quatre heures, la prescription ne pourrait-elle pas être renouvelée après 48 heures?

3. *Aérosols:* Ces traitements sont très longs et sont prescrits 3 à 4 fois par jour, et souvent pour une très longue période qui dure parfois jusqu'à deux mois. Les aérosols administrés par canule dans les cas de trachéotomie durent ½ heure pour 1 cc. de solution, et l'infirmière doit se tenir auprès du malade durant tout le traitement. Il est suggéré d'essayer de trouver le moyen d'établir une solution médicamenteuse plus concentrée ou de diminuer le nombre de traitements.

4. *Poids de malades:* Il est suggéré de reviser la routine qui exige la pesée des malades en médecine à tous les jours ou aux deux jours. Souvent, une ou deux fois par semaine suffirait, et ce, à jour fixe, si possible.

5. *Dosages:* On suggère qu'ils soient toujours faits sur prescription avec limite de temps.

6. *Medicaments:* Pour les médicaments prescrits au rythme de six pilules, 3 ou 4 fois par jour, il est demandé s'il n'y aurait pas possibilité de

trouver une formule qui réduirait la quantité sans altérer l'effet. On attire l'attention sur les oublis trop fréquents de cesser la prescription de certains médicaments.

7. *Cliniques d'O.R.L. & d'Ophtalmologie:* Les malades sont demandés à ces cliniques aux heures du diner. Il arrive tous les jours que trois ou quatre malades sont appelés, les uns après les autres, ce qui requiert du personnel pour les conduire. Et alors, nous avons sur l'étage un personnel réduit au moment même où nous en avons le plus besoin pour le service des plateaux.

8. *Heures des repas:* Il est suggéré que les visites des médecins, examens, traitements, histoires de cas, se fassent en dehors des heures de repas, afin de permettre aux malades de bien manger et aussi de simplifier le travail du nursing et du service des diètes.

9. *Ordonnances médicales:* Il est suggéré d'essayer de nouveau le système déjà préconisé quant aux prescriptions faites après les heures de revision, i.e., déposer la feuille d'ordonnances médicales dans le panier à cet effet. Les prescriptions oubliées le matin, lors de la visite, si elles ne sont pas urgentes, ne devraient être remplies que le lendemain. De plus, les tests devraient être prescrits le matin, lors de la visite, et non le soir de 5.30 à 6.00 heures, afin que les hospitalières aient le temps de les expliquer à l'élève.

10. *Sacs d'eau chaude pour lits d'opérés:* Les sacs d'eau chaude ne devraient pas être utilisés pour les lits d'opérés; c'est l'avis du chef du département d'anesthésie. Il est donc résolu de ne plus employer de sacs d'eau chaude, mais de changer le drap de coton pour un drap de flanellette dans les lits d'opérés.

11. *Toilette pré-opératoire:* Il est suggéré de ré-étudier la possibilité de faire effectuer ce traitement par des techniciennes et infirmiers de la salle d'opération, de 3:30 à 8:00 heures p.m. Ces personnes passeraient dans les départements. On croit que, de cette façon, le travail serait mieux fait.

Sur réception du rapport du Comité des Techniques théoriques et pratiques, le Comité spécial a tenu, à son tour, trois assemblées pour étudier ces suggestions. Voici ses recommandations:

a) *Tension artérielle:* La prise de la tension artérielle ne doit pas être considérée comme une routine du nursing. L'interne doit avoir la responsabilité et le contrôle de la tension artérielle. Dans certains cas particuliers, il peut déléguer cette fonction à une infirmière dès qu'il sera assuré que celle-ci a la compétence pour le faire. La prescription de la prise répétée de la tension artérielle doit comporter une limite de temps.

b) *Température:* La température sera prise deux fois par jour, les trois premiers jours d'hospitalisation pour tous les patients. Subséquemment, elle sera prise une fois par jour, sauf s'il y a hyperthermie ou à moins de prescription spéciale du médecin. Quant aux patients opérés et aux patientes accouchées, la température doit être prise deux fois par jour jusqu'à avis contraire du médecin traitant.

c) *Aérosols:* Seuls les médecins traitants ou les résidents prescriront les aérosols. La prescription d'aérosols ne sera effective que pour 3 jours à moins d'avis contraire sur la prescription.

d) *Poids:* Qu'un malade soit toujours pesé de routine à l'arrivée et au départ. Qu'en dehors de ces deux fois, la pesée ne soit faite que sur prescription médicale au dossier.

e) *Dosages:* Qu'aucun dosage ne soit fait de routine. Que toute prescription de dosage ne soit effective que pour 3 jours à moins d'avis contraire sur la prescription.

f) *Médicaments:* Déjà nous donnons à nos malades des médicaments dont les temps de désagrégation varient. Les doses se libèrent graduellement et de façon uniforme sur une période de 8 à 12 heures et même davantage. Par exemple, nous servons à un malade, le matin, une seule capsule Eskabarb, 1 grain. Elle remplace les quatre doses de phénobarbital, ¼ grain, qui auraient été administrées dans la journée, au même malade, soit à 9, 2, 6, et 9 heures. Plusieurs autres médicaments à action prolongée sont aussi prescrits pour nos malades.

g) *Sacs d'eau chaude:* Le sac d'eau chaude ne sera appliqué que sur prescription médicale. Que le degré de chaleur de l'eau ne dépasse jamais 105° F. à moins d'avis contraire sur la prescription.

h) *Ordonnances en dehors des heures régulières:* Que les prescriptions faites

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après l'heure de revision des dossiers (1:00 heure p.m.) soient déposées dans un panier marqué à cet effet à chaque poste. Que l'on place une affiche au-dessus de ce panier indiquant son usage.

i) *Rasage pré-opératoire:* Aucune recommandation. La discussion reste ouverte.

Ces recommandations reçurent l'approbation de l'Exécutif du Bureau médical, et furent adressées par lettre à la Directrice du Nursing, en date du 4 février 1957. La Directrice du Nursing convoqua une assemblée des responsables des départements et des représentantes de l'école pour leur annoncer les modifications apportées dans le soin des malades. De son côté, Monsieur le Directeur médical avertissait Messieurs les médecins et les internes.

Cette simplification des routines fut très bien appréciée par les responsables des départements. Quelques jours plus tard, elles nous faisaient rapport des premiers résultats.

Dans le service de médecine, on prenait une moyenne de 318 températures par 24 heures pour 139 malades; il n'en reste environ que 50 à prendre le matin. Dans le même service, on enregistrait les dosages d'à peu près la moitié des malades; cette proportion est passée de la moitié au tiers. Quant aux traitements d'aérosols, il y a une diminution marquée du nombre de traitements et de leur durée.

Cette simplification du travail permet aux infirmières de surveiller davantage les malades et leur personnel, et de répondre plus promptement aux demandes des médecins.

Ces préliminaires prouvent que la recherche en nursing est nécessaire et nous font espérer de notre étude des résultats au delà de nos prévisions du début.

Resume

A scientific study on nursing administration was planned by the Director of Nursing of Notre-Dame Hospital in Montreal. The aim of the project was "better use of knowledge and aptitudes of all nursing personnel — professional and non-professional."

The project which consisted of an analysis of the functions carried by all members of the personnel, was conducted by Mr. J. W. Willard, Director of the Division of Research, assisted by Mr. G. Josie and Mr. Charles B. Walker of the same Division. Four specially trained nurses also participated and acted as consultants. Four hundred observation periods of one-half hour each were conducted for eight categories of personnel in 14 nursing units.

The codification and analysis of 13,428 activities was a job which took time and minute patience. The facts already found showed that some of the work carried by nurses could be reduced with the cooperation of doctors.

The findings were presented to the Joint Committee; a special committee was set up to reduce treatment without prejudice to patients and to change routine treatments. The special committee presented eleven recommendations. Eight were immediately approved by the Medical Board.

The immediate result of the study is simplification of nursing tasks without affecting efficiency of treatment, better coordination of the nursing team and more time to look after personal needs of patients. The final conclusions are bound to bring even more radical changes.

The success of the study is due to the long preparation of the plan, information given at an early stage to all categories of personnel, the leadership of the consultants and the enthusiasm of the director of nursing.

When moving to a new area, it is wise to make arrangements for a family doctor. By having a medical checkup before illness or accidents occur, the new doctor will know the patient's medical history and have a better knowledge of his needs than if he meets the patient for the first time in an emergency.

—Dept. of National Health & Welfare

An interesting and "perhaps fruitful" line for study has been the discovery that a certain type of electronic instrument can stimulate, without any unpleasant sensations, the brain of a number of elderly patients whose memory has failed with the result that their memory span is markedly increased during the period immediately following treatment.

— *Mental Health*

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Senile Psychosis

IRMA ARBERY DICKSON

MRS. HAYES came to Canada from England with her husband and little daughter. Tragedy beset the little family — the young daughter was killed in a riding accident when she was nineteen years old and shortly after, Mr. Hayes died.

Mrs. Hayes managed a boarding house for a number of months to provide an interest for herself but before long she found that it was too much of a burden for her physically. Financially, she was very secure and found an apartment in which she lived alone. Her loneliness led her to accept invitations to attend spiritualist meetings and seances where she held conversations with her husband and daughter. This appeared to provide emotional satisfaction for her although her friends noticed that she seemed depressed after these meetings.

Eventually, the symptoms that were to require her admission to hospital four years later began to appear. She developed a feeling that people were stealing from her — in some instances she believed that her life was in danger. She had visual hallucinations of animals being killed. She had forebodings concerning future events and feared to go to sleep lest these events should occur during her sleep. A belief that her food was poisoned resulted in a refusal to eat. Her forgetfulness, delusions and bizarre behavior were making her an object of scandal and ridicule on the part of those who did not understand. A close friend, realizing that Mrs. Hayes was now much in need of institutional care, undertook the responsibility of having her admitted to a mental hospital.

At the time of her admission Mrs. Hayes was 72 years of age but looked much younger. She wore glasses but had very good vision without them. Her teeth were well cared for. The wrinkling of her skin showed that there had been some weight loss. She dressed neatly, was very cooperative and adjusted well to ward routines and the staff. Her personal habits were good. Although it was difficult to obtain much information regarding her past history, she carried the scars of a nephrectomy and cholecystectomy.

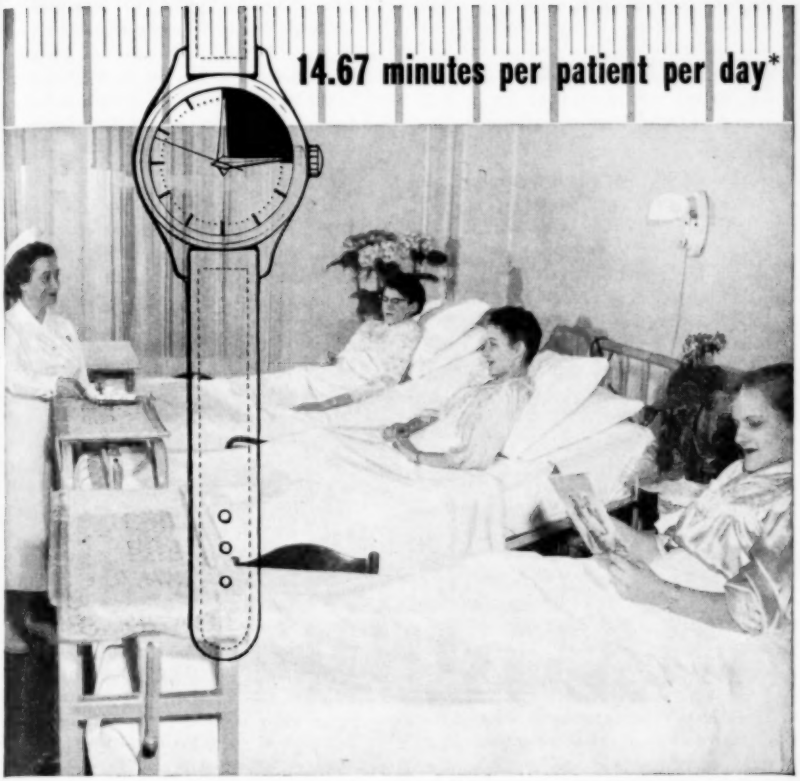
Mrs. Hayes had beautiful features, a lovely smile and a friendly if somewhat bewildered expression. Her posture was excellent. Her motor activity had decreased and there was some evidence of decreasing mental function since she had lost track of time. Apart from that Mrs. Hayes showed a fair degree of insight and understanding and a normal intelligence. Although she appeared to have to search for words to express her ideas, her emotions were suitable to her conversations.

Immediately following admission she was placed on high vitamin therapy. She was moved to various wards in an attempt to find the one on which she showed greatest improvement. A period of close observation was carried out on one of these wards in an effort to understand Mrs. Hayes better.

First day: Her nurse found her standing alone in the middle of her private room with an expression of complete bewilderment on her face. She wore no make-up and her hair hung down, long and stringy. She wore a well-cut grey skirt and yellow blouse which, while not soiled, showed evidence of having been worn for some time.

At mealtime she ate a sufficient quantity of food without complaint. She hesitated over taking her pill of nicotinic acid 100 mgm. — her only medication — because she felt that she did not need it. The doctor had ordered it to combat her increasing confusion. After lunch she sat in front of her door and chatted to one of the older patients. Later, she brought a box of crackers from her room and shared them with surrounding patients.

Mrs. Dickson, a graduate of Sherbrooke Hospital, Sherbrooke, Que., is on the staff of the Verdun Protestant Hospital.



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1. *E. G. Gooby and D. R. Turnbull: New Technic of Administering Medications, THE CANADIAN NURSE, (August) 1957.* †*Reg. Can. T.M. Off.*

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The first day's contact gave the impression of a cultured, reserved woman who had become slightly neglectful of her appearance because she had no one close to her to care. Friendly but not aggressive, she tended to grant full friendship only after evaluating the individual.

Second Day: When she came on duty in the morning her nurse found that Mrs. Hayes had already bathed and was getting dressed to go downtown with a friend. The nurse saw to it that she was given a complete change of clothing including a freshly cleaned suit. She helped Mrs. Hayes arrange her hair and put on her make-up neatly and attractively.

The other nurses complimented Mrs. Hayes on her appearance and this added greatly to her pleasure and excitement. She enjoyed her tour of a big department store and lunch at a restaurant with her friend.

It was obvious that she wanted to win approval of and interest in her appearance. The help that her nurse gave her won Mrs. Hayes' friendship and confidence. It gave her the feeling that someone cared.

On her return from her shopping tour Mrs. Hayes brought back some fried chicken to one of the other patients as a gift. She undoubtedly felt hurt when the patient refused it but after a while she offered it to the head nurse and was pleased with the appreciation her gift received. Mrs. Hayes' difficulty in putting her thoughts into words was further indicated on this occasion. She was unable to explain to her nurse a problem that was troubling her — apparently an incident that had occurred while she was downtown.

Third Day: This morning, she took about two hours to get dressed and had some difficulty in doing it properly. Her attempt at putting on make-up was not very successful. It seemed probable that she was trying to use up the time because she had nothing definite to do. The nurses' pleasure in her appearance when she wore make-up provided the necessary stimulus for her to try to put it on even if not too successfully.

She talked much more freely to her nurse and mentioned her daughter. However she was once more preoccupied with a problem that she did not understand and could not put into words. She sat alone in the hall for long periods although occasionally she chatted to one of the other ladies. Because she was not aggressive in nature, her choice of a seat in the hall in preference to her room was probably to allow her to take advantage of any friendship that might be offered.

Fourth Day: Mrs. Hayes dressed herself attractively in a smart black suit with a white blouse. She asked the nurse for assistance in putting on her make-up and arranging her hair. Her good taste in her choice of clothes and her interest in an attractive appearance stemmed from her upbringing and were retained in spite of her illness.

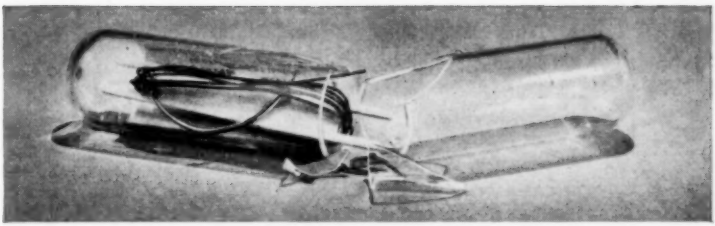
She questioned her nurse about her social activities and showed interest and excitement in her description of a previous evening's entertainment and her escort. Mrs. Hayes' daughter would have been just a few years older than her nurse. She tended to associate the nurse with her daughter and to take a motherly interest in her social life. She also showed signs of increasing confidence in her nurse and growing desire for her approval and attention. She resented slightly the attention required by other patients that tended to take the nurse away from her. She was flattered and pleased when the nurse asked her to attend a movie with her on the ward. She had been very active socially as a younger woman and enjoyed the stimulation of outside interests.

Fifth Day: Her interest in her appearance continued and she showed good judgment in her choice of clothes. She attended church service and expressed her pleasure in being able to do so.

The actions of another patient annoyed her but she was able to express her annoyance in words to her nurse. She also accepted the nurse's explanation of the patient's behavior.

Sixth and Seventh Days: Her acceptance of the nurse as her friend was shown by Mrs. Hayes' open demonstration of affection and her regret over seeing her nurse leave the ward at the completion of her training in that division. Mrs. Hayes chose one of the most dependable patients on the ward as her particular friend. She needed and wanted friendship and apparently used good judgment in her choice.

(Continued on page 956)



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[1]Alexander, Edythe L.: Mod. Hosp., May, 1957

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(Suite de l'édition de septembre)

LAURENCE CREVIER HAMEL

LA MÉDICATION

J'OUVRE ICI LA VUE, en parlant de la médication sur un vaste champ d'enseignement. Avec l'ère moderne, les variétés de pilules se multiplient à une rapidité incroyable. Bien intelligente est l'étudiante qui, à ses premières expériences, peut tirer parti de la situation sans aide et sans frustrer son malade de la sécurité auquel il a droit. Chaque laboratoire, de plus en plus nombreux, lance sur le marché avec un nom personnel, un nouveau comprimé, une nouvelle substance injectable. Il faut donc apprendre à l'étudiante à se familiariser avec cette kyrielle de substances prescrites. Ces médicaments arrivent sur les étages sans aucune présentation et n'ont que leur couleur attrayante et leur forme variée à offrir pour capter l'attention de l'étudiante. L'institutrice clinique doit alors se renseigner auprès du médecin et du pharmacien afin de connaître la substance du contenu. En effet, comment l'étudiante peut-elle savoir que le comprimé de "cintron" qu'elle administre à son malade est un anti-coagulant? Sa science libresque lui indique bien les dangers à redouter lorsque le patient est soumis à ce traitement, mais peut-elle identifier ce médicament comme tel, il a été offert à l'usage thérapeutique deux ou trois mois après la fin de ses cours théoriques?

Le but de la prescription doit également être indiqué. Il est excessivement dangereux de manipuler ces boules, ces carrés, ces losanges à l'apparence d'un bonbon mais à l'effet brutal parfois, sans en souligner la signification thérapeutique. Ainsi l'étudiante sait que sa malade fait une thrombose coronarienne et le médecin lui a prescrit "dicoumarol." Je lui explique alors pourquoi le médicament est administré et ce qu'elle doit observer par la suite. Il est facile de comprendre que cette étudiante est plus en mesure de faire une corrélation entre le malade et le comprimé, ce qui évite des erreurs toujours possibles. Forcément, elle observera par la suite, l'effet attendu ou les dangers à redouter d'une telle médication.

Que dire maintenant de la conversion des doses médicamenteuses? Ce "point faible" reconnu comme tel dans toutes nos écoles d'infirmières, mérite une attention particulière en enseignement clinique. Combien d'élèves préfèrent administrer une dose imprécise afin de camoufler une ignorance? A l'heure de la médication, je me rends sur les lieux et je vérifie. Un grand nombre d'entre elles calculent la dose exactement, mais ne peuvent motiver leur calcul, ce qui laisse un danger plus tard en face d'une dose rarement prescrite. D'autres sont dans l'erreur tout à fait et avouent leur difficulté sur ce point. Enseigner avec le matériel en main facilite la compréhension et la répétition grave plus profondément. Si un médicament est présenté dans une fiole de 10 cc., l'étudiante qui administre 100 milligrammes, doit savoir combien de cc. correspondent à la dose prescrite. Sur ce dernier point, il y a beaucoup à faire également. Cette méthode contribue à la prévention d'une série d'ennuis et d'erreurs pour la main inexpérimentée.

LES ANALYSES

La médication 1957 déborde d'activités. Comment préparer un malade pour analyse sans connaître sa valeur. L'intérêt de l'étudiante grandit toujours devant la responsabilité qui lui incombe, si elle comprend bien ce que

Madame Hamel est institutrice clinique à l'Hôpital Saint-Luc de Montréal.

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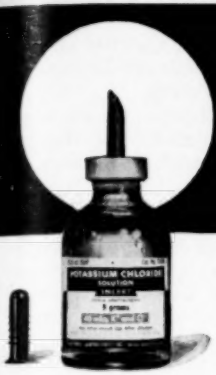

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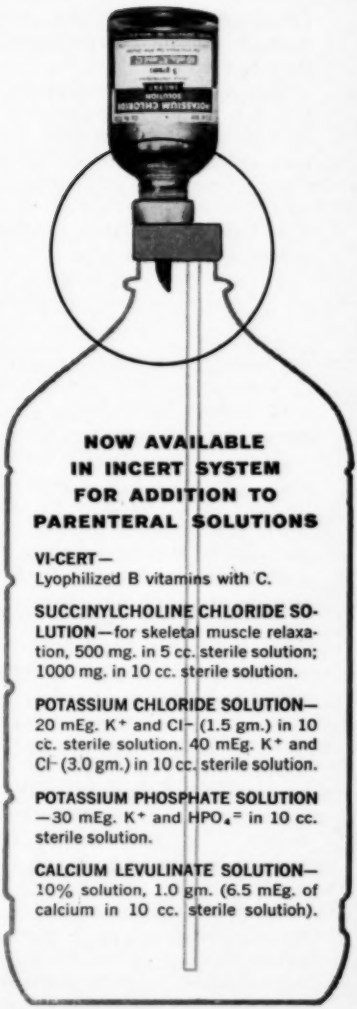

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POTASSIUM PHOSPHATE SOLUTION—30 mEg. K^+ and $HPO_4^=$ in 10 cc. sterile solution.

CALCIUM LEVULINATE SOLUTION—10% solution, 1.0 gm. (6.5 mEg. of calcium in 10 cc. sterile solution).

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les analyses apportent de lumière à un diagnostic. Elle coopérera avec exactitude et attendra la réponse du labo avec un intérêt scientifique particulier.

Si le métabolisme basal demandé est expliqué la veille, la préparation de cette malade sera respectée intégralement. Avec tact, l'étudiante lui transmettra ses connaissances afin de lui procurer la sécurité nécessaire à la réussite de l'épreuve. C'est encourageant de voir avec quelle finesse, l'étudiante surveille l'entourage de sa malade afin de lui procurer le plus de repos possible.

Que de temps avons-nous à consacrer à l'étudiante dans ce domaine? Si elle est bien persuadée du grand rôle qu'elle joue et de la nécessité d'une coopération intelligente, elle fera tout pour éviter la duplication des analyses, toujours aussi ennuyeuses qu'onéreuses pour le malade.

Admission des malades

C'est toujours avec plaisir que j'initie l'étudiante à recevoir ses malades. Il y a tant à retirer d'une réception sympathique que j'appuie beaucoup sur cette formation.

Après avoir salué la malade, déjà reçue par l'hospitalière, je présente l'étudiante à sa malade. Si le cas est bénin, je me retire pour retourner ensuite vérifier. Lorsque la malade est gravement atteinte; j'assiste l'étudiante afin de procéder à une bonne installation. J'observe la malade et les réactions de l'étudiante vis-à-vis les symptômes découverts ou à découvrir. Dès que la chose est possible, je passe à mon petit questionnaire et je peux dire maintenant que je réponds très souvent aux "pourquois" que l'étudiante me pose d'elle-même. D'après les signes notés, j'invite l'étudiante à indiquer le nursing correspondant au cas observé. Lorsque l'étudiante quitte le département, je peux affirmer qu'elle est en mesure de faire face à une admission d'urgence et de répondre aux exigences de la première heure, et ce sous tous les aspects. Ainsi le travail routinier de l'admission disparaît par la signification du pouls arythmique décelé, par la température élevée, accompagnée de dyspnée qui laisse supposer une affection pulmonaire, par la tension artérielle très basse, le faciès livide et le battement des ailes du nez qui indique immédiatement le nursing d'urgence du cas de shock.

En stimulant l'intérêt et en augmentant les responsabilités, le résultat est assuré pour l'étudiante qualifiée.

La surveillance clinique

Il me reste à parler de la surveillance exercée en enseignement clinique. Comme son nom l'indique, je vois tout simplement au-dessus des activités du champ clinique. Exception très rare, je ne fais aucune surveillance directe. Du seul fait de me pencher vers le malade, la surveillance se fait sans rigidité. S'il repose calmement dans son épreuve, c'est déjà une garantie sur le soin donné.

Ainsi, si une malade me demande le bassin de lit, en lui donnant combien je suis favorisée pour évaluer la propreté de l'étudiante auprès de sa malade. Toujours par le même geste, je suis en mesure de découvrir une dysurie, une diarrhée. Avait-elle été rapportée au dossier? Cette méthode me renseigne sur une foule de détails qui passeraient autrement inaperçus.

Je passe donc la journée avec les étudiantes au chevet de leurs malades. Elles travaillent sans se soucier de ma présence et je ne sens pas de tension nerveuse. Si j'ai à reprendre l'étudiante, sauf où il y a grande nécessité, je le fais en dehors de la salle afin de conserver intacte cette belle confiance que le malade lui témoigne; ceci me permet également de respecter son amour-propre. Si je fais face à une étudiante moins qualifiée et surtout moins active, je rencontre un peu plus de difficulté. Cependant, si après trois offenses identiques et signalées, il n'y a pas d'amendement, je la préviens et la dirige vers la directrice du nursing avec une note expliquant les faits.

A chaque erreur soulignée, j'enrégiste dans un cahier spécial, le récit du fait, le nom et la date, tout ceci à la connaissance de l'étudiante. Si l'erreur est grave, j'exige la signature de l'étudiante. Celle-ci est déjà au courant du but de ce mémoire: lui rendre justice lors de l'évaluation qui se fait à chaque mois et apprécier l'amélioration attendue. Cette évaluation est inscrite dans un cahier cumulatif, propriété de l'étudiante. Elle est faite en

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Carnation

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Optimum prescription-quality in today's trend to the individualized formula.

coopération avec l'hospitalière qui appose sa signature; celle de l'étudiante est demandée après avoir pris connaissance de son bulletin et enfin le cahier est remis à la directrice du nursing qui voit l'élève tous les mois.

Je fais donc une surveillance directe, seulement lorsque je doute de la franchise de l'étudiante. Aux premières offenses, j'accorde toujours le bénéfice du doute, mais je vais ensuite aux grands moyens afin de reprendre et corriger ce défaut absolument intolérable chez l'infirmière. J'avoue que par crainte, le changement s'opère pour quelque temps, mais à date j'ai toujours été déçue du résultat.

Avant de terminer, je voudrais mettre en valeur un autre facteur de cette surveillance indirecte. L'exemple est encore la forme la plus puissante d'enseignement. L'offrande d'un verre d'eau, la réinstallation d'un malade, l'aide à un hémiplégique à l'heure du repas sont des gestes d'amour et de charité et non pas une corvée réservée seulement à l'étudiante soumise à une discipline sévère.

Avantages des deux méthodes

L'enseignement collectif:

Cette méthode offre le précieux avantage de faire participer tout un groupe au même sujet traité:

Favorise la tenue des dossiers scolaires.

Incite l'élève à faire des recherches personnelles puisqu'elle est appelée à présenter le cas de sa malade.

Développe chez l'étudiante la facilité de transmettre ses connaissances.

Permet à l'institutrice clinique d'évaluer avec plus de justice l'expérience clinique de chaque étudiante.

L'enseignement individuel:

Cette méthode apporte une solution au problème du local pour les réunions, dans un hôpital ancien:

Résout également le problème de réunir un groupe en pleine activité, à une heure fixée.

Demande moins de préparation pour l'institutrice clinique.

Plus formatrice car l'enseignement individuel se fait plus facilement sous tous ses aspects.

Rappelle beaucoup moins l'aspect scientifique et atteint plus facilement les moins douées.

Identifie beaucoup plus l'institutrice à l'infirmière.

Développe l'initiative et assure une sécurité plus grande pour l'étudiante.

Permet plus facilement d'apprécier le sens de la responsabilité et les aptitudes de chacune.

Facilite l'évaluation de chaque étudiante.

Permet une surveillance discrète, mais précieuse.

Entretient de meilleures relations avec l'hospitalière: L'enseignement individuel lui apporte beaucoup d'aide, tandis que l'enseignement collectif lui vole son personnel, bien utile pour le service des malades.

Conclusion succinte

J'ai voulu mettre en évidence le rôle de l'infirmière institutrice clinique. J'ai insisté surtout sur la valeur de l'enseignement individuel comme étant le plus nécessaire; enseignement sans lequel, la formation des étudiantes, de plus en plus jeunes, semble impossible.

EXECUTIVE SECRETARY TREASURER

The Saskatchewan Registered Nurses' Association invites applications for the position of

EXECUTIVE SECRETARY TREASURER

Applicants must have experience in Nursing Service and Nursing Education.

Experience or postgraduate study in Administration would be an asset.

Apply in writing stating qualifications, experience and salary expected to:

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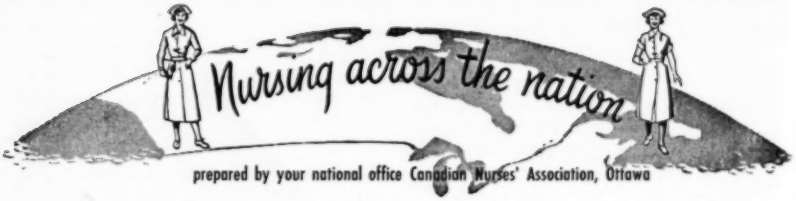

Canadian Conference on Nursing

OUR FIRST VICE-PRESIDENT was chatting with nurses abroad. In course of conversation she mentioned that the Canadian Nurses' Association was holding a conference on nursing this autumn to which ministers and department heads of federal and provincial governments, university personnel, and allied professions, had agreed to come. A look of amazement came over their faces. "Do you mean to say that in your country nursing enjoys sufficient prestige to allow you to call a meeting of Ministers, high government officials and heads of university departments, business, etc. and they will listen to you?"

To the affirmative reply the response was, in effect — "You, in Canada, don't know you're living!"

This is our first Canadian conference on nursing. It is important! Perhaps one of the most important things we have done or can do. Not because of tremendous decisions which this Conference can or will make but because we have sat down with a cross section of the Canadian public to look at nursing problems, many of which we have been conscious of for a long time. We shall hear things we like. We may, and no doubt shall hear things we do not like. Let us learn from both!

Secretary of the Canadian Conference on Nursing Appointed

On the recommendation of the Planning Committee, Miss Lola Wilson has been appointed Executive Secretary of the Canadian Conference on Nursing. Miss Wilson will be in National Office for three weeks preceding the conference to devote full time to detailed planning. This will include the compilation of reports of provincial committees and the preparation of a study brochure for participants. Following the conference, Miss Wilson will devote a few days to the follow-up study of the discussions and will prepare the final report.

If we know Miss Wilson, and we think we do, every detail of the conference will be most adequately taken care of.

The Pilot Project off to a Good Start

At time of writing (August 15) the funds for the Pilot Project stand at $23,968. We acknowledge with grateful appreciation and in the name of the Canadian Nurses' Association, the following additional contributions made by cheque or pledge —

The Registered Nurses' Association of Nova Scotia — $1,000.00 The Registered Nurses' Association of Ontario — $5,000.00

The Director's Program with the National League

Much time and thought has been put into Miss Mussallem's experience with the National League for Nursing. The Educational Division of the League under the direction of Miss Helen Nahm, A.B., M.S., Ph.D., has arranged Miss Mussallem's program in such a way that she will have experience not only in the evaluation of a variety of schools but also with several evaluators. While studying the accreditation program of the National League, Miss Mussallem is planning its adaptation with respect to evaluation of Canadian nursing.

International Figure will attend 50th Anniversary Convention

Miss Daisy Bridges, R.R.C., S.R.N., S.C.M., the Executive Secretary of the International Council of Nurses has accepted an invitation to be with us for

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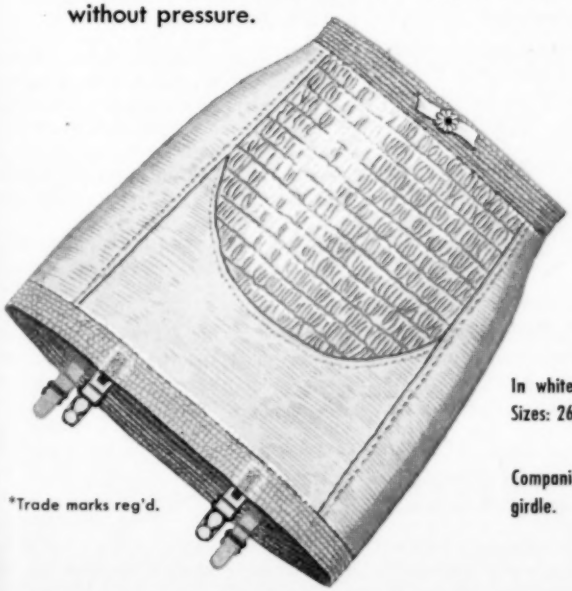

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the 50th Anniversary Biennial meeting in Ottawa next year. Miss Bridges is a graduate of the Nightingale School of Nursing, St. Thomas' Hospital, London. She later attended the Radcliff Infirmary, Oxford, for her midwifery preparation. She studied hospital administration under the Florence Nightingale International Foundation and in 1937-38 studied in the United States and Canada. Miss Bridges has had a broad professional experience and a distinguished army record as matron, principal matron, and command matron. She has served as President, National Council of Nurses of Great Britain and Northern Ireland and as Chairman, Executive Committee, London Branch, Royal College of Nursing. Miss Bridges will deliver the keynote address at the opening session of our CNA Convention.

Pre-registration forms are now ready — and will appear next month in this journal. Please register early. This will save you the crush of crowds at the registration desk. It assists the nurses responsible for arrangements in seeing that you will be well taken care of. It helps National Office by having one more of the expected 3,000 registrants in the fold.

A Past President Honored

The highest international nursing award, the Florence Nightingale Medal has been granted to Miss Helen McArthur, R.N., M.A., National Director of Nursing Services, Canadian Red Cross Society. Established in 1912, this gold medal bearing the likeness of Florence Nightingale is given for outstanding contributions towards the development and prestige of the nursing profession.

A Study Tour for British Nurses

On the request of the National Council of Nurses of Great Britain and Northern Ireland, National Office is organizing a study tour for nurses from the British Isles. If plans develop the nurses, some 30 of them, will come to Canada in April or May of next year. Through provincial associations and in small interest groups, the tour will provide observation in various fields of nursing. Regretfully, time does not permit an extensive tour of our country for it must be fitted into the nurses' vacation period. Even so, sight seeing and shopping will be worked in so that our guests will get at least a glimpse of our Canadian way of life.

The Macmillan Company appoints Editorial Consultant

The Macmillan Company of Canada appointed an Editorial Consultant in the person of Dr. E. Kathleen Russell. With Miss Russell's assistance, Macmillan's hope to build up a list of Canadian nursing books.

The Provincial Associations hold Annual Meetings

The Registered Nurses' Associations of New Brunswick, Prince Edward Island, Quebec and Manitoba are holding annual meetings this month or next. The General Secretary has accepted an invitation to attend the Manitoba meeting.

Canadian Nurses Contribute to CARE Programs

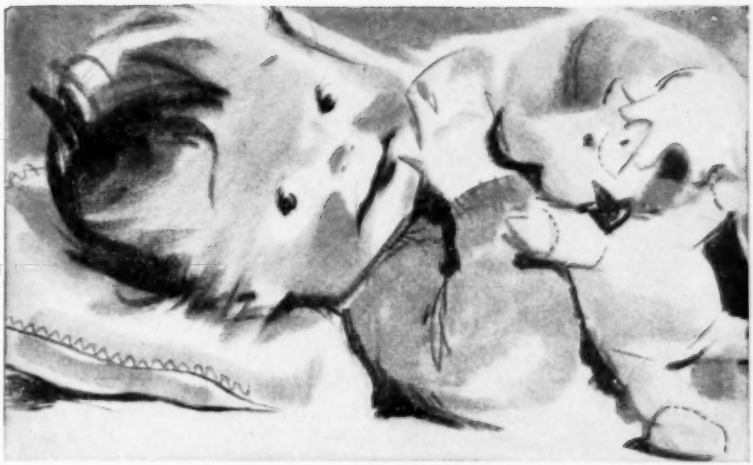
CARE of Canada has informed National Office that nurses who wish to remain anonymous have contributed to the work of CARE. Acknowledgement of $60.00 given in one month has been received with a letter of appreciation from Saigon, Vietnam. The letter reads —

> The blankets were given to the needy in the highland regions of Vietnam where the nights are cold and damp. The cloth and mosquito nets were given to needy families, orphanages, old age homes and hospitals. These gifts represent a tremendous sum of money to these people who, in their poverty, are living on a substandard existence, and they send their thanks to you who remembered them.

So long as we love we serve; so long as we are loved by others I would almost say that we are indispensable; and no man is useless while he has a friend. — *Selected*

Doing easily what others find difficult is talent; doing what is impossible for talent is genius.

—Henry Frederic Amiel



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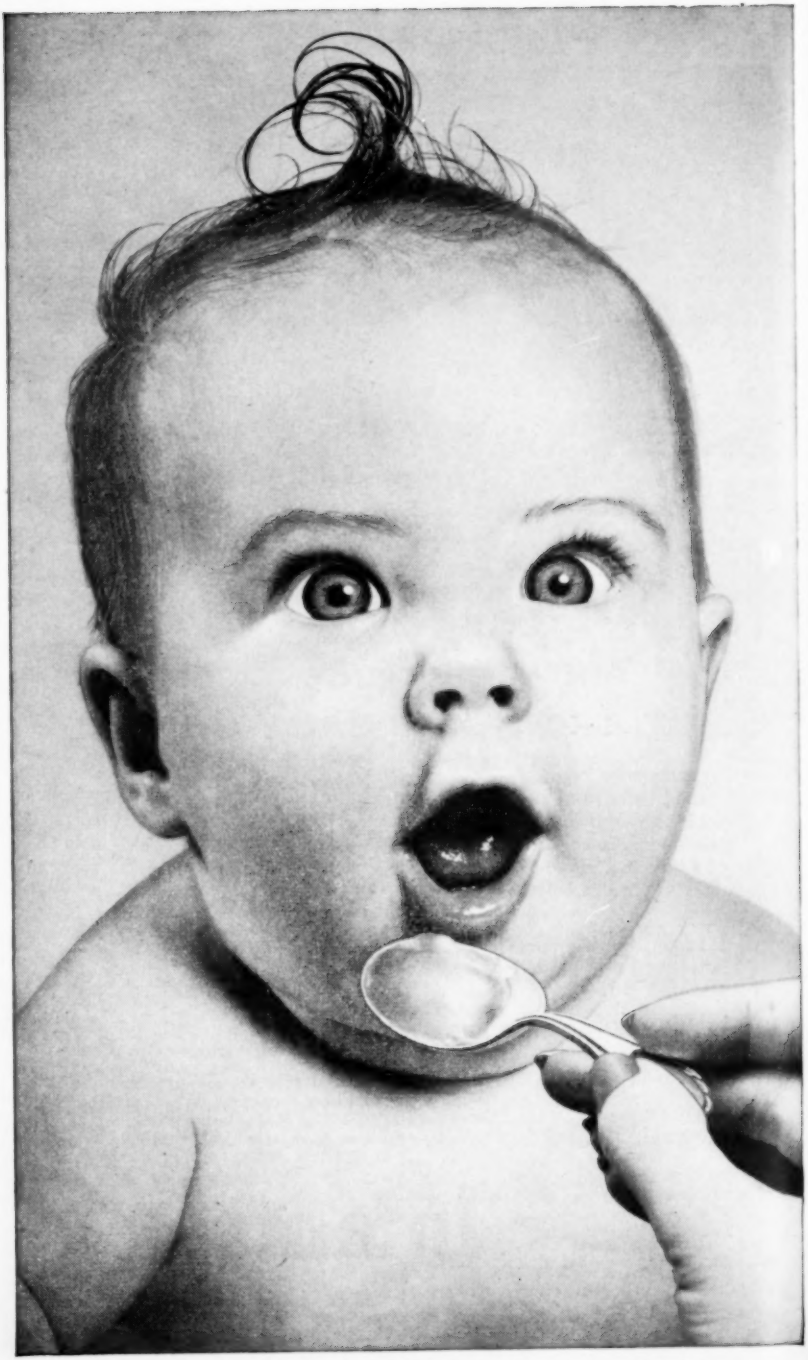

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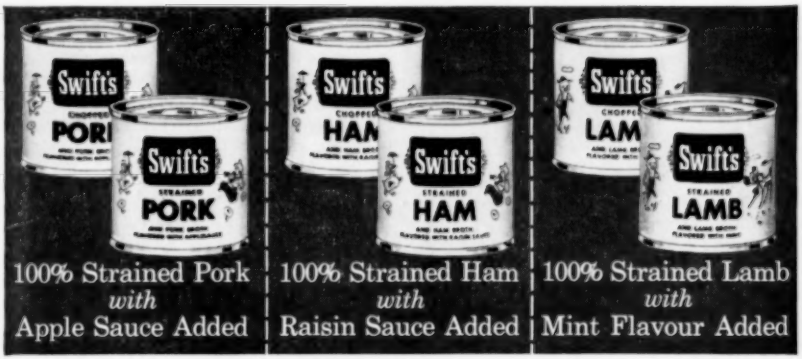
Meats for Babies!



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As a doctor, you know that some babies take to meats from the start. Other babies take a little longer to become acquainted with meat's distinctive flavor.

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All three are 100% meat, with a bit of fruit and mint added for tempting flavor. They're smooth, too. So smooth babies take to them easily, quickly. They're high in protein and very easy to digest.

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Le Nursing à travers le pays

Conférence canadienne sur le Nursing

Lors de son voyage en Europe, notre première vice-présidente, causant avec des infirmières, mentionna au cours de la conversation que l'Association des Infirmières canadiennes tiendrait une conférence à l'automne à laquelle des ministres et chefs de services des gouvernements fédéral et provinciaux avaient accepté d'assister; les universités et les professions connexes y seront aussi représentées. Elles semblèrent tout à fait étonnées. "Voulez-vous dire que dans votre pays le nursing jouit d'un tel prestige pour vous permettre d'inviter à une assemblée des ministres, des chefs de services de vos gouvernements, des représentants d'universités, etc. etc. et que tous vous écoutent?"

A la réponse affirmative la réplique fut: "Vous, au Canada, vous ne savez pas toute la chance que vous avez".

C'est notre première conférence canadienne sur le nursing. C'est un événement de grande importance, peut-être le plus important jusqu'à présent non pas tant à cause des décisions qui seront prises mais bien parce que nous aurons le privilège de délibérer sur les problèmes du nursing en présence de représentants du grand public canadien. Nous entendrons probablement des choses qui nous feront plaisir et d'autres qui nous plairont moins: sachons tirer une leçon des deux.

Nomination de la Secrétaire de la Conférence canadienne sur le Nursing

A la recommandation du Comité chargé du plan de la conférence, Mlle Lola Wilson a été nommée secrétaire de la Conférence canadienne du Nursing. Mlle Wilson sera au Secrétariat Général durant les trois semaines qui précéderont la conférence afin de voir aux détails de l'organisation. Elle devra compiler les rapports des comités provinciaux, voir à la préparation d'une brochure qui sera remise aux participants pour étude. Mlle Wilson demeurera quelques jours à Ottawa après la conférence dont elle rédigera le rapport final.

Connaissant Mlle Wilson comme nous croyons la connaître, rien ne sera laissé au hasard nous en sommes sûres et tout sera bien fait.

Le projet d'accréditation va bon train

Au moment où nous préparons cette chronique (15 août) les fonds du projet d'accréditation sont de $23,968. Nous accusons réception, et remercions au nom de l'Association des Infirmières canadiennes, des contributions suivantes reçues ou promises:

L'Association des Infirmières enregistrées de la Nouvelle-Ecosse — $1,000.00.
L'Association des Infirmières enregistrées de l'Ontario — $5,000.00.

La directrice du programme d'accréditation et la National League for Nursing

Rien n'a été épargné pour que Mlle Mussalem retire le plus de bénéfices possible de son stage à la National League for Nursing. Le département de l'éducation sous la direction de Mlle Helen Nahm, A.B., M.S., Ph. D., a organisé le programme de Mlle Mussalem de façon qu'elle ait de l'expérience non seulement dans l'évaluation de différentes écoles mais voit aussi le point de vue de différents évaluateurs. Tout en étudiant le programme d'accréditation de la National League, Mlle Mussalem ne perd pas de vue l'adaptation d'un tel programme à l'évaluation du nursing au Canada.

Personnage international invité au Cinquantenaire de l'A.I.C.

Mlle Daisy Bridges, R.R.C., S.R.N., S.C.M., secrétaire du Conseil International des Infirmières a accepté l'invitation d'assister au Congrès biennal qui marquera le 50ième anniversaire de l'A.I.C. et qui se tiendra à Ottawa l'an prochain. Mlle Bridges est diplômée de l'Ecole d'Infirmières Nightingale de l'Hôpital St. Thomas de Londres. Elle suivit ensuite le cours de sage-femme au Radcliff Infirmary, à Oxford. Elle étudia l'administration hospitalière sous les auspices de la Fondation Internationale Florence Nightingale et vint étudier aux Etats-Unis et au Canada de 1937 à 1938. Mlle Bridges possède une vaste expérience professionnelle; elle s'est distinguée dans l'armée comme matronne, matronne principale et matronne en chef. Elle a été présidente du Conseil National des Infirmières de Grande-Bretagne et de l'Irlande du Nord et présida également

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le Comité Exécutif du Royal College of Nursing, District de Londres. Mlle Bridges prononcera le discours d'ouverture du Congrès.

Les formules pour l'inscription à l'avance sont disponibles et seront reproduites dans la revue du mois prochain. Vous êtes priées de vous inscrire à l'avance; cela évitera l'encombrement de la dernière minute au bureau d'inscription; cela aidera aussi aux infirmières chargées de l'organisation à vous assurer tout le confort possible. Chaque infirmière qui s'inscrira à l'avance allégera d'autant la tâche du Secrétariat National qui s'attend de recevoir 3,000 membres.

Honneur à une ancienne Présidente!

Le plus haut prix international de nursing, la médaille Florence Nightingale, a été décernée à Mlle Helen McArthur, R.N., M.A., directrice nationale des Services du Nursing de la Société canadienne de la Croix-Rouge. Etablie en 1912, cette décoration consistant en une médaille d'or à l'effigie de Florence Nightingale, est accordée en reconnaissance de services extraordinaires ayant contribué au progrès et au prestige de la profession d'infirmière.

Voyage d'Etude pour les Infirmières britanniques

A la demande du National Council of Nurses of Great Britain and North Ireland, le Secrétariat national est à organiser un voyage d'étude pour les infirmières britanniques. Si ce projet se réalise, environ 30 infirmières viendront au Canada l'an prochain vers les mois d'avril ou mai. Par l'entremise des associations provinciales, des infirmières divisées par petits groupes et selon leurs intérêts particuliers, feront des visites d'observation dans les différents domaines du nursing. La courte durée de ce voyage qui sera les vacances de ces infirmières ne leur permettra pas de traverser le pays. Tout de même elles auront le temps de faire des excursions et quelques emplettes qui leur permettront d'avoir un aperçu de la vie canadienne.

La Maison d'édition Macmillan s'adjoint une rédactrice consultante

Dr. E. Kathleen Russell vient d'être nommée consultante au service de rédaction de la maison Macmillan Company of Canada. Avec l'aide de Mlle Russell, cette maison d'édition espère publier une série de manuels canadiens sur le nursing.

Assemblées Annuelles d'Associations Provinciales

Les associations provinciales du Nouveau-Brunswick, de l'Ile-du-Prince-Edouard et du Manitoba tiendront leur assemblée annuelle au début de l'automne. La secrétaire-générale a accepté d'assister à celle du Manitoba.

Les Infirmières canadiennes contribuent à l'organisation CARE

L'organisation CARE du Canada vient d'informer le Secrétariat National que des infirmières, désirant demeurer anonymes, ont souscrit au fonds de CARE. L'on a accusé réception d'une somme de $60.00 et envoyé la lettre suivante, de Saigon, Vietnam:

> Les couvertures furent remises à des personnes dans le besoin, des régions hautes du Vietnam où les nuits sont froides et humides. Le linge et les moustiquaires ont été distribués parmi des familles pauvres, des orphelinats, hospices et hôpitaux. Ces dons représentent une grande valeur pour ces personnes dont le niveau de vie est peu élevé; elles remercient ceux qui pensent à elles.

Sélection

Le Régime et les niveaux lipides du sérum.

Des données extraites d'une revue de la statistique nationale des approvisionnements alimentaires et de l'état civil de dix pays révèlent que c'est aux Etats-Unis que les taux de mortalité par artériosclérose et maladie coronarienne sont les plus élevés, que c'est au Japon qu'ils sont les plus bas, qu'ils sont plus élevés chez les hommes que chez les femmes, et que, dans tous les pays, ils augmentent avec l'âge.

L'artériosclérose est reliée de quelque façon avec le métabolisme des lipides: on constate une élévation du cholestérol sérique

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chez les êtres humains qui ont des symptômes de cette maladie.

On constate que le régime joue un rôle important dans la régularisation du niveau des substances lipides qui se trouvent dans le sérum sanguin. C'est chez les populations qui ont les approvisionnements alimentaires les moins abondants que l'on constate les niveaux sanguins de cholestérol et de lipides connexes les plus bas. Les niveaux de cholestérol sanguin diminuent chez les êtres humains lorsque la ration calorique est restreinte et qu'il y a perte de poids. On constate le contraire lorsqu'il y a augmentation de poids, conséquence de l'excédent de calories.

Dairy Council Digests, National Dairy Council, Chicago, vol. 28, No 2, novembre 1956.

Annual Meeting in Saskatchewan

The fortieth annual meeting of the S.R.N.A. was held in Saskatoon early in the year with an attendance of 284 members. Mary T. MacKenzie, president, presided at the sessions.

The report of the executive-secretary, Lola Wilson, reviewed the activities of the provincial office. The registrar, Grace Motta, reported a total of 3,123 nurses registered in the province as of December, 1956 — an increase of 201 over the figure of the previous year. Certification of nursing assistants began in December, 1956 and in April, 1957 a total of 202 had been certified.

Several interesting panels, discussions and addresses highlighted the convention.

Living is Learning — This panel discussion was under the chairmanship of E. James. Participants included Professor M. P. Toombs, College of Education, University of Saskatchewan; G. Hawkins, associate director, Canadian Association for Adult Education; H. Hobbs, Supervisor of Staff Health, University Hospital; O. Smith, Director of Nursing, Saskatoon City Hospital.

The Present Scope of Cardiac Surgery was the subject of an address by Dr. E. M. Nanson, professor of surgery, University of Saskatchewan. This was followed by a symposium on the nursing care of the cardiac surgical patient. All aspects of care including the special investigation needed before surgery, preoperative care, postoperative care, and public health implications were included in the discussion.

Chapter Presidents Show You How was a presentation under the direction of L. Long that portrayed dramatically the method of conducting a chapter meeting.

Why Public Relations in the Nursing Field? was discussed by Dr. D. L. Gibson, Dept. of Dairy Science, University of Saskatchewan. This address was an outstanding highlight of the convention.

Professional Training — Philosophy and Common Sense was the subject chosen by another guest speaker, G. Hawkins, associate director, Canadian Association for Adult Education. His remarks were thought-provoking and challenging.

A luncheon meeting featured Dr. H. Osmond, superintendent of the Saskatchewan Hospital, Weyburn when he gave a doctor's views on nursing.

A number of major by-law revisions were approved by the membership. Included in these was approval of the inclusion of the subscription to *The Canadian Nurse* in the annual fees.

At the closing session the slate of officers elected for the current year was announced. They were: L. Willis, president; M. Earnshaw, L. Miner, vice-president; E. James, V. Antonini, L. Long, P. L. Wright, committee chairmen.

LOLA WILSON
Executive-Secretary, Treasurer
Saskatchewan Registered Nurses' Association.

The Rainbow Bridge deck at Niagara Falls is 1,450 feet long and has two 22-foot roadways separated by a four-foot wall from which the bridge is lighted. There is a 10-foot sidewalk on the south side facing the Falls for pedestrians. There are 12 approach traffic lanes on the U.S. side and 14 on the Canadian side. The steel arch span of the bridge is 960 feet long from pin point to pin point and is said to be the largest fixed steel arch span in the world. Between 6,000-7,000 tons of steel were used in its construction.

— *Ontario Government Services*

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Book Reviews

Emergency Removal of Patients and First-aid Fire Fighting in Hospitals by Lieutenant Robert McGrath. 59 pages. A joint publication of the National Safety Council and the American Hospital Association. 1956.

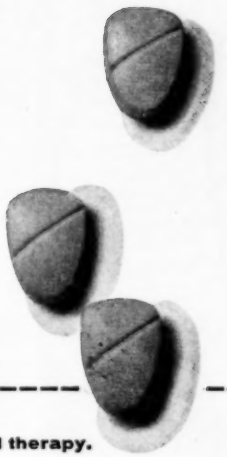
The information in this manual is a fire inspector's answer to the request of nurses for more specific and practical application of fire safety principles. Nurses know that, in the event of fire, patients in immediate danger must be removed. But what is the safest and quickest method of removing a patient from a burning oxygen tent? What is the quickest way to evacuate a nursery full of helpless babies? And how do you go about carrying a helpless adult to safety without a stretcher, etc.?

In any safety program *preparedness* is essential. We tend to place a rather blind faith in our so-called "fireproof" modern buildings. In reality they are only "fire-resistant" and this, in turn, is directly proportionate to good architectural planning, generous provision and convenient arrangement of fire-fighting equipment and adequate training of personnel in the techniques of fire-fighting and emergency removal methods. The manual deals with these and other important points briefly and explicitly.

Emergency removal of patients receives major consideration. This section is generously illustrated with a simple, clear explanation accompanying each photograph. The various holds and carries that may be used by one nurse, two nurses or more are demonstrated. The necessity of practice is emphasized. Each nurse should find the carry method best suited to her. Practice in the use of fire-fighting equipment, a knowledge of the various types of extinguishers and their uses, and the necessity for teamwork in such an emergency are of equal importance.

This manual has a very definite place in the ward library where it is readily available to all members of the staff. It is equally valuable in the early instruction of student nurses in hospital safety and for

The majority of adult **DIABETICS** will respond to MOBENOL



How to select patients for Mobenol therapy.

Generally, a majority of those diabetics whose condition developed in maturity — after age 40 — and whose insulin requirements are low or moderate will respond to Mobenol.

Best chance Majority will respond	Diabetes developed after 40 and requires less than 40 units of insulin daily.
Fair chance up to 30% will respond	Diabetes developed between 20 and 40 years of age and is relatively stable.
Poor chance under 10% will respond	• Diabetes developed under age 20. • Unstable diabetes (ketonuria promptly follows insulin withdrawal) • High insulin requirements or insulin-resistant.

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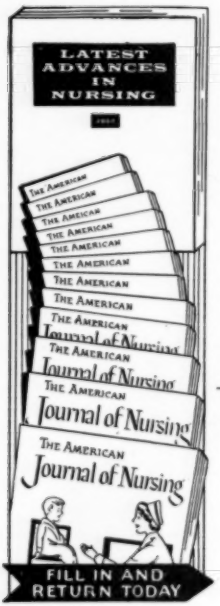

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Again this year, the editors of the American Journal of Nursing have selected from the twelve issues published in 1956, a total of 150 particularly and permanently useful clinical and practical reports for republication in a compact 88-page anthology, which will be included free with any *new* subscription placed by a member of your Provincial Nurse's Association within the next 30 days, at the regular modest annual $4.50 rate.

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civil disaster instruction in the institution or the community.

Textbook for Midwives by Margaret F. Myles. 676 pages. The Macmillan Company of Canada Limited, 70 Bond Street, Toronto, 1955. Price $3.40.

Reviewed by Miss Eunice Martin, Supervisor, General Hospital, St. John's, Newfoundland.

The outstanding feature of this book is the admirable manner in which the practical side of obstetric nursing is emphasized. Its descriptions would be very clearly understood by a nurse starting out fresh in obstetrical nursing. Such descriptions as "shedding of the placenta — if the placental attachment is limited to the loose spongy layer, it will be possible for the placenta to become separated from the decidua in much the same way as postage stamps can be readily detached at their line of perforation," or in the chapter on Physiological Changes due to Pregnancy "the cervix becomes soft, its consistency is comparable with that of the lips, while the cervix of the nonpregnant uterus feels like the tip of the nose."

This book gives you not only the medical aspect of midwifery but also the social aspects applicable more especially to Great Britain. The illustrations and clinical photographs are good. The information is extremely complete, clear and comprehensive. This would be a very excellent and useful reference book for the pupil midwife, the midwife or nurse working in an outpost station or in an area where medical help is not always immediately available.

Operating Room Technic, St. Mary's Hospital, Rochester, Minn. 359 pages. W. B. Saunders Co., Philadelphia. 5th ed., 1957. Price $7.50.

Reviewed by Miss Muriel Ward, Clinical Instructor, Operating Room, Toronto Western Hospital.

The fifth edition of this valuable operating room reference text is enlarged not only in the number of pages but vastly in content. Grouping of operative procedures is reorganized with thoracic surgery now segregated from general surgery which includes abdominal and gynecological routines. New chapters include cardiovascular surgery and plastic surgery.

New pediatric findings[1] show
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One large group of infants suffered constipation, another group intestinal disturbances and malaise, coincident with teething.

The result from the studies were as follows . . .

ALL CONSTIPATED BABIES were relieved with complete easing of straining at stool, gas discomfort, restlessness and crankiness.

ALL TEETHING BABIES suffering concomitant gastrointestinal disturbances and malaise were relieved except one. Disturbed sleep, restlessness, crankiness were relieved as well as anorexia and constipation when present.

EMINENTLY SAFE — "Throughout the study . . . in no instance was there any untoward reaction; no cutaneous eruptions or other allergic manifestations,

no petechiae, no rise in rectal temperature, no alteration in cardiac and respiratory function, no vomiting or diarrhea, no oliguria, no albuminuria. No significant changes were observed in weight, growth, development or hemoglobin before and after the period of medication."

Pleasant, convenient BABY'S OWN TABLETS provide Phenolphthalein 1/16 grain, mildly buffered with Precipitated Calcium Carbonate 1/2 grain, and Powdered Sugar q.s.

Send for a sample supply and literature citing references.[1-12]

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An enlarged index of illustrated instruments is located at the end of the book. The excellent photographs and diagrams are more numerous and generally larger for greater clarity of examination as is the book itself by approximately a quarter of an inch in both width and length.

Anyone who is familiar with previous editions of this text will be unsatisfied until this latest edition is on her library shelf.

* * *

The nursing station railway car, operating throughout the 350 miles of the Hudson's Bay division of the Canadian National Railways has been redecorated and facilities improved . . . This unique nursing station car began work in 1953. Since then it has treated 2,392 patients aboard, another 1,230 patients have been visited in their homes and 712 children examined in schools. Immunization of children, inoculations and nutrition improvement are the main objects.

* * *

It is in trifles, and when he is off his guard, that a man best shows his character.
—Arthur Schopenhauer.

* * *

Put off until tomorrow what you ought not to do at all.

—Poor Richard, Jr.

(Continued from page 932)

The high vitamin therapy that was ordered soon after Mrs. Hayes' admission improved her condition markedly. She no longer had hallucinations or delusions although she still tended to be somewhat confused and forgetful. After a certain amount of experimental moving about from one ward to another, it was decided that Mrs. Hayes reacted best in a quiet environment under fairly close supervision. Too much activity tended to increase her confusion. Unfortunately her confusion and forgetfulness made it necessary to curb her activities somewhat and to refuse her ground privileges. It also made the possibility of transferral to a nursing home a matter of doubt although Mrs. Hayes would have liked to leave the hospital.

This was an example of senile psychosis aggravated by loneliness and, to a certain degree, by vitamin deficiency. Therapy produced relief from the hallucinations and delusions that produced bizarre behavior and tended to alienate Mrs. Hayes from the friendship that she needed. The confusion and forgetfulness that may tend to develop with increasing years would not likely decrease and it seemed probable that Mrs. Hayes would have to have supervisory care from then on.

* * *

An apple tree puts to shame all the men and women that have attempted to dress since the world began.

—H. W. Beecher

Victorian Order of Nurses

The following is a list of staff changes in the Victorian Order of Nurses for Canada.

Appointments — *Mildred Campbell* (St. Jos. Hosp., London) to London. *Shirley Gerth* (Montreal Gen. Hosp.) to Hamilton. *Barbara Goodman* (Kingston Gen. Hosp.) to Collingwood, Ont., as nurse in charge. *Barbara Irwin* (Toronto West. Hosp.) to Toronto. *Evelyn Jaques* (Grace Hosp., Windsor) to Windsor. *Rose Kepka* (Royal Vic. Hosp., Montreal) to Montreal. *Stella*

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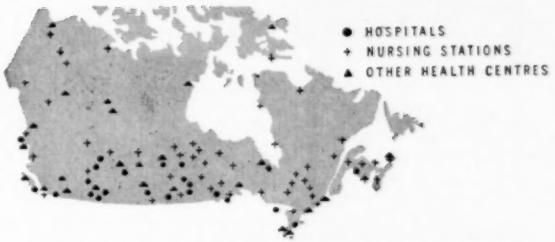

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(4) Hospital Staff Nurses: up to $3,540 per year depending upon qualifications and location.

(5) Nursing Assistants or Practical Nurses: up to $195 per month depending upon qualifications and location.

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(1) Regional Superintendent, 4824 Fraser Street, Vancouver 10, B.C.

(2) Regional Superintendent, c/o Charles Camsell Indian Hospital, Edmonton, Alberta.

(3) Regional Superintendent, 735 New Federal Building, Regina, Saskatchewan.

(4) Regional Superintendent, 522 Dominion Public Building, Winnipeg 1, Manitoba.

(5) Zone Supervisor of Nursing, Box 292, North Bay, Ontario.

(6) Zone Supervisor of Nursing, P.O. Box 3427, St. Roch Branch, Quebec, Que.

(7) Moose Factory Indian Hospital, Moose Factory, Ontario.

or

Chief, Personnel Division, Department of National Health and Welfare, Ottawa, Ontario.

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Candidates will not be permitted to write these examinations until their course has been successfully completed & until they hold the diploma of the school.

Applications may be obtained from:—

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and must be returned with the fee of twenty dollars BEFORE October 15, 1957, to the above address.

Legge (Halifax Infirmary) to Halifax. *Elizabeth Mayhew* (Royal Vic. Hosp., Montreal) to Chatham, N.B. as nurse in charge. *Joan Moyer* (Kitchener-Waterloo Hosp.) to Oakville. *Ida Packham* (St. Jos. Hosp., London) to Kitchener. *Eloise Stewart* (Victoria Hosp., London) to Saskatoon. Mrs. *Barbara (Brooks) Peace* (Hamilton Gen. Hosp.) to Burlington, Ont.

Transfers — *Denise Belisle* from Ste Anne de Bellevue to Lasalle, P.Q., as nurse in charge. Mrs. *Susanne Cornelisse* from Vancouver to Burnaby. *Ann Gilbert* from Newcastle, N.B. to Sackville as nurse in charge. *Donna Nash* from Ste Anne de Bellevue to Port Colborne as nurse in charge. *Gwen Sergeant* from Sudbury to Medicine Hat as nurse in charge. *Marion Van Noort* from Kentville, N.S. to Calgary.

News Notes

NEW BRUNSWICK

CHATHAM

The graduating classes of the Hotel Dieu and Miramichi hospitals were guests of honor at the annual chapter dinner held earlier this year. A toast to the new graduates was given by Mrs. B. Norris welcoming them into the profession. It was responded to by Miss Barry of Hotel Dieu Hospital. The guest speaker was Dr. R. D. Landry, public health officer, who chose stress as the subject of his talk and discussed it in relation to modern living. Miss Fraser thanked the speaker.

SAINT JOHN

General Hospital

In May, 1956 a Montreal branch of the school of nursing alumnae was formed through the efforts of Mrs. Hilda (Wainwright) Peters who became the first president. Meetings are held every three to four months in the homes of the members. The chief objective of the group is to keep graduates in touch with one another and aware of developments within their home school.

A set of brass andirons was purchased by the Montreal alumnae and placed in the new nurses' residence. At a recent meeting at the home of Mrs. Isabel (Kinsmen) Saxby, the following members were elected to office: Mrs. K. Gallivan, pres.; D. MacDonald, sec. and Mrs. Mary (Simpson) Gaskin, treas. Other graduates living in the Montreal area are invited to join the group.

ONTARIO

District 5

Toronto

Western Hospital

K. Peebles and M. Cooper have been appointed to head nurse positions. L. Shaw has joined the V.O.N. and is working in Welland. M. Hamilton is attending the University of Western Ontario and H. Niskala is doing postgraduate study in England. M. Kinsman has enrolled in the public health nursing course at the University of Toronto. M. Speck and A. Goulding have joined Trans Canada Airlines and L. Van Patter is on the educational staff of her home hospital.

QUEBEC

Montreal

Instructor's Group

The last two meetings completed the work of the members on the subject of evaluation. The guest speaker on one occasion was Miss Alice Wright, registrar of the R.N.A.B.C., and an active member of the National League for State Board Examination. Miss Wright discussed the test pool examinations in detail — the historical background, administrative problems, advantages and disadvantages.

Rev. G. Emmett Carter, director of St. Joseph's Teachers' College, discussed "The Psychology of the Mature Student" at the final session. He used as a basis for his discussion the normal phases of growth and development motivating the eighteen-year-old person. These factors must be considered in developing a satisfactory educational program and he gave suggestions for the development of such a program.

Quebec City

Jeffery Hale's Hospital

Miss K. Marshall has taken over her duties as director of nurses replacing Miss M. Jameson. J. Radley Walters has joined the teaching staff. Mr. J. H. Ottman, chairman of the board of governors, was the guest speaker at the annual dinner held by the alumnae association in honor of the graduating class. Dr. J. M. Gallea addressed the new graduates on the occasion of their graduation ceremony. S. Fenwick received the prize for general proficiency; A. Weir, the prize for bedside nursing; J. Russell, the prize for surgical nursing; J. Walsh, the award for achieving the highest mark in the theory of gynecological nursing and M. LaFrance, the prize for proficiency in her final year of study.

An isolette incubator was donated to the hospital by the alumnae association. Mrs. J. L. Meyers, president, made the presentation on behalf of the association. Mr. K. Nicholson, administrator, accepted it for use in the hospital.

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Superintendent of Nurses for new 32-bed hospital in West Kootenay region of B.C. Salary & increments according to experience & qualifications. Must be registered in B.C. **Operating Room Supervisor & Graduate Nurses.** Posts vacant early in 1958. Apply now with full details of experience etc. to Administrator, Box 706, Castlegar, British Columbia.

Matron for modern 30-bed hospital. Duties to commence immediately. **Private 3-room suite. 4-wk. annual vacation with pay after 1 yr. service. All statutory holidays. 44-hr. wk.** Full-time Sec.-Treas. For further particulars contact Robert G. Keast, Sec.-Treas., District Hospital, Roblin, Man.

Hospital Superintendent for modern 28-bed hospital (Duties to commence November 15, 1957.) Supervisory ability necessary. Excellent living quarters. Apply stating references, age, experience & salary expected to Sec., Mrs. M. S. Leslie, The Executive Committee, Bingham Memorial Hospital, Matheson, Ontario.

Matron, General Duty Nurses (2) for 23-bed hospital. Top salaries. 1-mo. vacation a yr. Separate nurses' residence. Maintenance: $25 per mo. Sick leave. Apply to the Matron, Union Hospital, Spiritwood, Saskatchewan.

Nursery Supervisor for new Nursery Unit. Postgraduate study or previous experience desired. Good personnel policies. Apply to Director of Nursing, General Hospital, Belleville, Ontario.

Night Supervisor and **General Duty Nurses** for 60-bed hospital to be increased to 100 beds in fall. Good personnel policies. Residence accommodation available. For further information apply, Superintendent, Alexandra Marine and General Hospital, Goderich, Ontario.

Operating Room Supervisor (Postgraduate course in O.R. technique required) for 140-bed hospital. Full maintenance. Travel arrangements. For particulars write Matron, King Edward VII Memorial Hospital, Bermuda.

Supervisory & Staff Nurses (Men & Women) for fully accredited private psychiatric hospital near Baltimore, Maryland. 40-hr. wk. 4-wk. annual paid vacation. Salaries dependent oo educational background & experience. **Living accommodation available on campus.** Apply Personnel Office, The Sheppard & Enoch Pratt Hospital, Towson 4, Maryland.

Assistant Evening & Night Supervisor — Salary minimum: $270 per mo. plus meals & laundry. **Assistant Head Nurses** for Medical & Surgical Wards — Salary Minimum: $240 per mo. plus meals & laundry. (800-bed hospital) Preparation & experience recognized. Apply to Director of Nursing, Royal Alexandra Hospital, Edmonton, Alberta.

Medical—Surgical Instructor. Classroom & clinical teaching. Classes approximately of 20-students. Apply Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

Clinical Instructor, Laboratory Technician for well-equipped hospital — small training school. Apply Superintendent, Carleton Memorial Hospital, Woodstock, New Brunswick.

Pediatric Head Nurse with postgraduate or equivalent experience. Operating Room Nurses & General Duty Nurses for 110-bed hospital in the Fraser Valley, 68 mi. from Vancouver with good bus service. Personnel practices in accordance with the R.N.A.B.C. policies. Accommodation in residence if desired. Further particulars available. Apply Director of Nursing, General Hospital, Chilliwack, B.C.

Head Nurses & Registered General Duty Nurses for surgical, medical & obstetrical depts. Gross salary for nurses currently registered in Ont.: $235 per mo. — extra allowance made for Head Nurses. Good Personnel policies. New facilities. Comfortable nurses' residence. 8-hr. rotating shift, 44-hr. wk. 1-day off 1-wk., 2 the next. 1½ day holiday allowed per mo., same sick time accumulated to 90 days. 8 legal holidays per yr. The equivalent of single train fare paid up to $40 after 1-yr. service. Apply Superintendent, Lady Minto Hospital, Cochrane, Ont.

Assistant Head Nurses, Assistant Operating Room Nurse & Staff Nurses. Excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Ave., Montreal, Quebec.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & post graduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

McKellar General Hospital, Fort William, Ontario requires **General Duty Staff Nurses** interested in coming to northwestern Ontario. Basic salary, $225 per month. Good personnel policies. Renovation program now complete. Openings in all departments. For further information apply to the Director of Nursing.

Registered Nurses for General Staff Duty & Operating Room in modern hospital opened February, 1957 & situated in the midst of one of Canada's most prosperous mining districts. Beginning salary:: $240 per mo., plus annual bonus plan, merit increase in 6-mo. to $250 per mo., subsequent increases to $270. Sick leave accumulative to 60-days. Free laundering of uniforms. Partial refund of transportation. Apply Director of Nursing, Memorial Hospital, Regent St. S., Sudbury, Ontario.

Staff Nurses for 600-bed General & Tuberculosis Hospitals with student programs. In central valley, city of 108,000. State & Junior Colleges afford opportunity for advanced education. Salary $320 with 4 annual increases to $360. Full maintenance $45 per mo. Liberal personnel policies. Apply Assoc. Director of Nursing Service, County General Hospital, Fresno, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Staff Nurses: Salary range: $315-$391; rapid advancement to Head Nurse, range: $351-$436. 200-bed modern hospital in "Heart of Feather River Recreation Area," near proposed Feather River Dam site. Liberal fringe benefits. 40-hr. wk. 12 holidays. 2-wk. vacation. 1-day sick leave per mo. accumulative to 60 days. Night & P.M. differential. Retirement plan. Group Health Ins. & maintenance available. Apply Director, Nursing Service, Butte County Hospital, Oroville, California.

Graduate Staff Nurses for 400-bed, well-equipped teaching hospital. Experienced nurses start at $320 per mo. days, $350 evening & nights. Room accommodation in attractive residence at reasonable rates. Convenient transportation to colleges & Loop. Apply Director of Nursing Service, Dept. CJN, Mount Sinai Hospital Medical Center, 2750 West 15th Place, Chicago 8, Illinois.

Staff Nurses for modern 650-bed Tuberculosis Hospital affiliated with Western Reserve University approved by joint commission on accreditation of hospitals. 40-hr., 5-day wk. Beginning salary: $286 with automatic increases. Advancement for eligible applicants. Full maintenance available at minimum rate, housing for 2 or more nurses. Meets approved minimum employment standards of the State Nurses' Association. Apply Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio.

Registered General Duty Nurses (2) immediately for 76-bed fully modern hospital on C.P.R. main line & Trans-Canada Highway to Calgary & Banff. Gross salary: $230 per mo. Perquisites $30. $5.00 increment every 6 mo. 8-hr. day, 44-hr. wk. 1 mo. annual vacation with pay. Sick leave with pay. Apply to Matron, Brooks Municipal Hospital, Brooks, Alta.

Registered Nurses (2) immediately for 30-bed hospital within 1-hr. drive from Waterton National Park, ½-hr. from Lethbridge & 4-hr. from Calgary & Great Falls, Montana. Salary: $230 per mo. gross. $5.00 increases at the end of 6 & 12 mo. Straight 8-hr. rotating shifts. 44-hr. wk. 3-wk. vacation with pay after 1-yr. plus all statutory holidays. Apply Matron, Municipal Hospital, Magrath, Alberta.

Registered Nurses (Immediately) for 31-bed hospital. Salary: $252 per mo. with annual increments of $10 per mo. Excellent single room accommodation in comfortable nurses' home free, meals at nominal rates (or full maintenance $30 per mo.) 28-day annual leave plus 3-day travelling time. Steamship fare from Vancouver or Prince Rupert refunded after 6 mo. Full recreational facilities in pleasant surroundings in this modern up coast town. For full information please write to the Matron, General Hospital, P.O. Box 640, Ocean Falls, British Columbia.

Registered Nurses for modern 20-bed hospital. Salary: $210 per mo. plus maintenance, $5.00 semi-annual increase. Good working conditions & living quarters. 8-hr. rotating shift, 44-hr. wk. Sick leave. 1-mo. vacation after 1-yr. Regular statutory holidays. Apply Deloraine Memorial Hospital, Deloraine, Manitoba.

Registered Nurses (2) for 16-bed modern hospital. Salary: $200 & full maintenance, $5.00 increment each 6-mo. for 4 increases. 8-hr. day, 44-hr. wk. 3-wk. vacation with pay after 1-yr. service plus statutory holidays. Apply to A. C. Laughlin, Secretary, Wilson Memorial Hospital, Melita, Manitoba.

Registered General Duty Nurses. Salary minimum: $230, maximum: $265. Evening duty additional $10. 40-hr. wk. Statutory holidays, liberal sick time, pension plan, holiday allowance. Accommodation available in nurses' residence, uniforms laundered free. Apply Superintendent of Nurses, Winnipeg Municipal Hospitals, Morley Ave. E., Winnipeg 13, Manitoba.

Registered General Duty Nurses, Certified Nursing Assistants for new 58-bed hospital, situated in northwestern Ontario. Gross salary: $227 per mo & $170 per mo. subject to increase after 6-mo., with regular annual increases thereafter. $45 per mo. room & board. New 21-bed nurses' residence — single rooms. Rail fare refunded after 1-yr. Apply stating age & when available to Director of Nursing, District General Hospital, Dryden, Ontario.

Registered General Duty Nurses for 25-bed General Hospital. Salary: $225-$250. 1-mo. vacation after 1-yr. Excellent personnel policies. Apply Superintendent, Englehart & District Hospital, Englehart, Ontario.

Registered General Duty Nurses. Excellent personnel policies. 40-hr. wk. Apply Nursing Director, St. Andrews Hospital, Midland, Ontario.

Registered General Duty Nurses for 28-bed General Hospital. Good salary & personnel policies. 44-hr. wk. Adjacent attractive residence. Recreation facilities. For further particulars apply Miss A. Burnett, Superintendent, Niagara Hospital, Niagara-on-the-Lake, Ontario.

Pembroke Cottage Hospital invites applications from **Registered & Graduate Nurses.** Excellent working conditions. 3-wk. vacation & 14-day sick leave after 1-yr. service. 7 statutory holidays. Blue Cross participation. Apply Director of Nursing, The Cottage Hospital, Pembroke, Ontario.

Registered General Duty Nurses for 200-bed General Hospiital, Salary $235 per mo. with annual increase. 5½ day wk. Good personnel policies. Apply Director of Nursing General Hospital, Sault Ste. Marie, Ontario.

Registered & Grace Graduates, General Duty Nurses. 44-hr. wk. 3-wk. vacation after 1-yr. All statutory holidays. 2-wk. sick leave. Apply Superintendent, Public Hospital, Smiths Falls, Ontario.

Registered Nurses for Recovery Room, Head Nurse & General Duty. New salary scale & personnel policies on request. Apply stating age, experience, when available, salary expected to Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke St. E., Montreal 5, Que.

Registered Nurses for modern 60-bed General Hospital situated 40 mi. south of Montreal. Salary: $210 per mo., $5.00 increase every 6-mo. for 5 increases. Monthly bonus for permanent evening & night shifts. 44-hr. wk. Many attractive benefits. Board & accommodation available at minimum cost in new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Quebec.

Registered or **Graduate Nurses** (3) required immediately for 45-bed hospital. Salary according to S.R.N.A. schedule; $5 increments every 6 mos. $50 travel expenses allowed after 1 yr. service. Maintenance, $30 monthly. 4 doctors on staff. Daily bus service to North Battleford and Saskatoon. Apply, Matron, Union Hospital, Meadow Lake, Sask.

Registered Nurses for General Duty Staff. Salary commences at £40-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for 105-bed General Hospital. Salary $330-$360 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Director of Nursing, Glenn General Hospital, Willows, California.

Registered General Duty Nurses for 118-bed General Hospital along the shores of Lake Michigan, 25 mi. from Chicago. Base salary: $300. Additional differential of $30 for evenings & $20 for nights. 5 day wk. Good personnel policies. Apply Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Registered Nurses for 38-bed General Hospital. Salary: $270 with periodic increases. Excellent personnel policies. For further information apply Superintendent, City Hospital, Red Wing, Minnesota.

Nurses — eligible for registry — immediate openings for general duty & surgery. Starting salary: $275 per mo. 40-hr. wk. Maintenance furnished if desired. Hospital located 12 mi. south of Portland with educational & cultural advantages; near mountains & seashore. Apply to Director of Nurses, Oregon City Hospital, 515 Tenth St., Oregon City, Oregon.

Registered Nurses for staff nursing in new & beautifully equipped 100-bed hospital in the Pacific northwest. Only 6 mi. from the Pacific Ocean. Delightful climate. Beginning salary: $290 for 40-hr. wk., $10 additional for p.m. & night duty. Apply Director of Nurses, County General Hospital, Tilamook, Oregon.

Registered General Duty Nurses (100-bed.) Good bedside nursing required. 40-hr. wk. Rotating duties. Excellent personnel policies. You can arrange for R.I. State Registration. Apply Nurse Director, Jane Brown Memorial Hospital, Providence 3, Rhode Island.

Registered Nurses! Spend your winter in the Sunny Southwest — New Mexico, "The land of Enchantment." Vacancies for staff duty in Medicine, Surgery, Obstetrics, Pediatrics, T.B. San (adults and children) and Operating Room. Salaries: $285-$315, days; $10 differential for evenings and nights; $15 differential, operating room. No shift rotation. Excellent job benefits. Board and room in nurses' residence, $43 per month. Free transportation via 1st Class Air travel to Albuquerque and return in exchange for a 1-yr. employment contract. Write or call collect Mrs. Margaret Nelson, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Ave. S.E., Albuquerque, New Mexico. Phone 3-5611.

Graduate General Duty Nurses (1) for 16-bed hospital. Salary: $230 per mo. less maintenance of $25 per mo. Increase of $5.00 per mo. for each 6-mo. of service up to 2 yrs. Income Tax deductions & Blue Cross on a 50-50 basis. 1-mo. annual leave with pay after 1-yr. service. Hospital is centrally located between 2 lake resorts, etc. Apply Mrs. J. Bergquist R.N., Matron, Municipal Hospital #43, Bentley, Alberta.

Graduate Nurses for 64-bed General Hospital (Construction on modern new wing to start this summer.) Salary: $230 per mo. if Alberta registered, less $30 for room & board. $5.00 increment after 6-mo. 28-day vacation after 1-yr. service. Statutory holidays, 1½ day sick leave per mo. Living accommodation. Travelling expenses up to $50 paid after 1-yr. service. Apply Sister Superior, Providence Hospital, High Prairie, Alberta.

Graduate Nurses (2) immediately for newly decorated small country hospital (40-mi. paved road to Grande Pairie.) Starting salary: $230 less $30 room & board. Laundry free. Good working conditions. Fare will be refunded after 12-mo. service. Apply Matron, Municipal Hospital, Hythe, Alberta.

Graduate Nurse (Immediately) for 18-bed hospital. Starting salary: $240 per mo., $5.00 increment every 6-mo. Board & Room, $40 per mo. Usual holidays. Apply Matron, Lady Minto Gulf Islands Hospital, Ganges, British Columbia.

Graduate Nurses for 28-bed hospital, pleasant surroundings. Salary: $250 per mo. less $40 per mo. room, board & laundry. Yearly increments. 4-wk vacation after 1 yr. service. 1½ days per mo. sick leave yearly, accumulative. Comfortable nurses' home. Please apply Administrator, Community Hospital, Grand Forks, B.C.

Graduate Nurses for new, very modern 88-bed hospital in a pleasant progressive town. Nurses salary: $200 per mo. Annual increase $10 per mo. for 3 yrs. 2-wk. shift rotation bonus for night shifts. 1 hr. drive to Toronto & several resorts. Local swimming pool, bowling alleys, skating, theatres etc. Apply Director of Nurses, Dufferin Area Hospital, Orangeville, Ont.

Graduate Nurses. Positions available at 398-bed, non sectarian, acute, general hospital with fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Apartments available in immediate neighborhood. Apply, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th Street, Cleveland 6, Ohio.

General Duty Nurse for 17-bed hospital. Salary: $230 gross. $5.00 per mo. increase after each 6 mo. up to 3 increases. Transportation refunded after 6-mo. service. 1 mo. vacation after 1-yr. service. 2-wk. sick leave each yr. paid for if not used. Apply Municipal Hospital, Elnora, Alberta.

General Duty Nurses (3) immediately for new 54-bed hospital. 5½ day wk., 8-hr. duty. 3-wk. vacation after 1-yr. service, plus 10 statutory holidays. Voluntary pension plan in operation. Apply giving experience, training & salary expected to Matron, J. McPhee, Municipal Hospital, Vermilion, Alberta.

General Duty Nurses (2) for 35-bed hospital. Salary: $206 per mo. plus full maintenance. 4 increments at $5.00 per mo. after each 6-mo. 1-mo. vacation with pay per yr. Sick leave & hospitalization benefits. Refund of train fare from any point in Canada after 1-yr. employment. Apply to Municipal Hospital, Two Hills, Alberta. Telephone: 335.

General Duty Nurses, $255. 40-hr. wk. 28-day vacation yearly plus 10 statutory holidays. Sick leave 1½ days monthly, accumulative after 6-mo. Room & full board $25 per mo. Fare from Vancouver advanced or refunded after 6-mo. service. Apply Matron, St. George's Hospital, Alert Bay, British Columbia.

General Duty Nurses. Salary: $240-$280, $10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, 1 mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

General Duty Nurses & Operating Room Nurses for 430-bed hospital; 40-hr. wk. Statutory holidays. Salary $240-$273. Credit for past experience & postgraduate training. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses (4). Come West to the sunny Okanagan Valley at St. Martins Hospital in Oliver, British Columbia. Particulars on application. Please apply to hospital.

General Duty Nurses. Starting salary: $248 per mo., $10 additional for 2 yr. continuous past experience. 4 annual increments of $10 per mo. to B.C. Reg'd. nurses. $20 per mo. for one or more years university training & $10 per mo. for hospital postgraduate clinical training of not less than 4 mo. 28 days annual vacation after 1 yr. service, 10 statutory holidays per yr. 1½ days sick leave per mo. cumulative. Room rent at nurses' residence $20 per mo. Promotions to senior positions from permanent staff. For details apply Director of Nursing, Trail-Tadanac Hospital, Trail, B.C.

General Duty Nurses for new 85-bed hospital. Good salary & generous personnel policies. Apply to the Director of Nursing, Portage Hospital Dist. #18, Portage la Prairie, Manitoba.

General Duty Nurse: The Blanchard-Fraser Memorial Hospital (71-bed) located in Kentville, Nova Scotia, offers a General Duty Nurse ideal working conditions. 1 mo. annual vacation, excellent personnel policies plus modern living quarters with full maintenance in new nurses residence. For further information apply to Superintendent of Nurses.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

General Duty Nurses for 35-bed hospital, 50-mi. from Toronto. Salary: $230, with $10 annual increase for 3-yr. Evening & night differentials, $10 per mo. Rotating shifts. Living accommodations in comfortable residence. Apply to Superintendent, Stevenson Memorial Hospital, Alliston, Ontario.

General Duty Nurses for all departments. New addition to hospital recently opened. Good personnel policies. Apply to Director of Nursing, General Hospital, Belleville, Ont.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $225 per mo. with annual increments. Good personnel policy with sick leave benefits, holidays & paid vacation. Residence accommodation available. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for 107-bed accredited hospital. Starting salary: $240 per mo. Differential for evening & night duty. Periodic increases. Travelling expenses from point of entry into Ontario refunded after 6-mo. service. 44-hr. wk. 21-day vacation with pay, 8 statutory holidays, accumulated sick time. Medical & hospital plan subsidized. Apply Supt. of Nurses, Kirkland & District Hospital, Kirkland Lake, Ontario.

General Duty Nurses & Certified Nursing Assistant for 70-bed General Hospital. Apply Acting Director of Nursing, Ross Memorial Hospital, Lindsay, Ontario.

General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics. Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

General Duty Nurses for all departments. Gross salary: $225 per mo. if registered in Ontario, $205 per mo., until registration has been established. $20 per mo. bonus for evening or night duty; annual increment of $10 per mo. for 3 yrs. 44-hr. wk., 8 statutory holidays, 21 days vacation & 14 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing, General Hospital, Oshawa, Ont.

General Duty Nurses. Opening new wing in October. Registered Nurses starting salary: $190 plus full maintenance 8-hr. duty, 5½ day wk. Accumulated 5 or 6 days off following 2-wk. night duty. Apply Saugeen Memorial Hospital, Southampton, Ontario.

General Duty Nurses for 100-bed JCAH approved county general hospital in San Joaquin Valley. Located centrally between San Francisco and Los Angeles. Salary: $314-$371 plus $10 for evening and night shifts. 40-hr. wk.; 12 statutory holidays; 3-wk. vacation; liberal sick time. Rooms available in modern nurses' home, $10 monthly. Apply to Supt. of Nurses, County General Hospital, Tulare, Calif.

General Duty Nurses, Operating Room Nurses for 64-bed acute treatment, fully accredited hospital in northern California. Excellent living conditions. For full details at once on salaries, working conditions, paid vacations, paid holidays, paid sick leave & other benefits apply to Director of Nursing Services, Woodland Clinic Hospital, Woodland, California.

General Duty Nurses for 50-bed hospital located in mountainous portion of Colorado. Salary: $290 plus fringe benefits. Opportunity for advancement and increase in salary. Registration requires graduation earlier than 1952 or 3 months each in psychiatry and pediatrics segregated services. Apply, Superintendent, Community Hospital, Alamosa, Colorado.

Floor Duty Nurses for modern 50-bed General Hospital. Salary: $235 per mo. gross for registered nurses. Annual increment $60; extra pay for shift work. Apply Superintendent, Leamington District Memorial Hospital, Leamington, Ontario.

Scrub Nurses (Immediately) for 500-bed General Hospital with school of nursing. Basic salary: $245 per mo. with increments for 2-yr. service or more, or postgraduate study. 40-wk. Must be eligible for B.C. registration. Apply Director of Nursing, Royal Jubilee Hospital, Victoria, British Columbia.

Operating Room Nurse for modern Operating Room suite. Experience preferred. Please apply stating salary expected to Superintendent, Lady Minto Hospital, Cochrane, Ont.

General Staff Nurses for 370-bed approved General Hospital with intern & resident program. $300 per mo. starting salary. $15 per mo. increases at 6, 12, 24 & 36 mo. 40-hr. wk. Paid vacation, paid sick leave. 7 paid holidays. Pleasant coast city in outstanding recreational area. Apply Director of Personnel, Seaside Memorial Hospital, Long Beach 13, California.

Delivery Room Nurses (to rotate hours of duty) for new Obstetrical Dept. Good personnel policies. Apply to Director of Nursing, General Hospital, Belleville, Ontario.

Chief Dietitian for 140-bed hospital. Training school affiliated with Montreal hospitals. Fare paid. For particulars write Matron, King Edward VII Memorial Hospital, Bermuda.

Public Health Nurse for generalized program in area adjacent to Edmonton. Duties to commence October 1. Salary: $3312-$3600 depending on experience and with certificate in PHN. 3 wk. annual vacation; pension plan; Blue Cross; Medical Services Plan; adequate sick leave. Car furnished on duty. Apply, Medical Officer of Health, Stony Plain-Lac Ste Anne Health Unit, Stony Plain, Alta.

Public Health Nurse Grade 1. British Columbia Civil Service, Dept. of Health & Welfare. Salary range: $290-$345 per mo. depending on experience. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in British Columbia & have completed a University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province.) Cars are provided. A 5-day wk. in most districts. Uniform allowance. Further information may be obtained from the Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C. Applications obtainable from all Government Agencies, the Civil Service Commission, 544 Michigan St., Victoria, or 411 Dunsmuir St., Vancouver, to be completed & returned to the Chairman, Civil Service Commission, 544 Michigan St., Victoria, British Columbia.

Public Health Nurses for generalized program in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group ins. & transportation arrangements. Apply Dr. R. M. King. York County Health Unit, Newmarket, Ontario.

Public Health Nurses (2). Qualified, Experienced (preferably). Immediately for a generalized public health nursing service. State salary expected. Annual increment. Transportation provided. 5-day wk. Pension & hospitalisation plans employer shared. Apply Miss Gertrude H. Tucker, Supervisor, Public Health Nursing, Board of Health, City Hall, 50 Centre St., Oshawa, Ontario.

Public Health Nurses (qualified.) Salary: $3,100 depending on dist. served, less if in the Timmins area. Annual increment $150 per annum for 4 yrs. Additional allowance for experience & if French-speaking. 5-day wk. 4-wk. vacation, 18 days sick leave annually (cumulative). Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ontario.

Superintendent for 35-bed hospital, duties to commence Nov. 1, 1957. Complete staff at present time. Apartment in residence. Apply stating references, age, experience & salary expected to Sec.-Treas., County of Bruce General Hospital, Walkerton, Ontario.

Assistant Operating Room Supervisor for 250-bed General Hospital. Postgraduate course preferred, previous experience considered. Good personnel policies. For further information apply to Director of Nursing, General Hospital, Belleville, Ontario.

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Surgical Registered Nurses, Staff Registered Nurses for 240-bed General Hospital. 40-hr. wk. 15 working days. Paid vacation. 7 Paid holidays. Surgery, starting base pay: $338, stand-by & call back time extra. Staff R.N., starting pay: $322 monthly. Regular pay increases. Apply Yolo General Hospital, P.O. Box 210, Woodland, California.

Registered Nurses (2) immediately for new modern 25-bed hospital. 3-wk. vacation after 1-yr. service. 8 statutory holidays. Residence accommodation. Apply Superintendent, Tobique Valley Hospital, Plaster Rock, New Brunswick.

Public Health Nurses for generalized program for the City of Belleville Board of Health. Salary based on experience. 5-day wk. 4-wk. vacation with pay. Sick leave credits. Blue Cross Plan, 50% of same paid by city., P.S.I. also available. Pension Plan. Liberal car allowance. Apply to Dr. McColl Metcalfe, Medical Officer of Health, City Hall, Belleville, Ontario.

General Duty Graduate Nurses (2). Salary: $250. Room, board & laundry: $40. 28-day vacation after 1-yr. service. All statutory holidays paid. Customary sick leave. Graduate complement, 5. Apply giving full details to Matron, Slocan Community Hospital, New Denver, B.C.

Registered Laboratory Technician (Available for duty October 21st.) Well organized dept. **General Duty Registered Nurses.** Living in accommodations. Personnel policies equal to best. For full particulars apply to Superintendent, Queens General Hospital, Liverpool, Nova Scotia.

Laboratory & X-Ray Technician for active 35-bed hospital, 50-mi. from Toronto. Good living accommodation in nurses' residence. Good personnel policies. For further information please apply to Superintendent, Stevenson Memorial Hospital, Alliston, Ontario.

Registered or Graduate General Duty Nurses for 20-bed modern hospital. Salary: R.N.'s; $240 - Grad.; $220. Increment after each 6-mo. service. Maintenance $30 per mo. 1-mo. vacation with pay after 1-yr. service. Separate staff residence. Apply Matron or Sec.-Manager, Riverside Memorial Hospital, Turtleford, Saskatchewan.

Supervisor for 7-Theatre Operating Room. 370-bed approved general teaching hospital with new building program. 650-750 cases monthly. Applicants should have experience in similar situation with added preparation in operating room work. Salary open. Pleasant coast city of 300,000, mild climate, 21-mi. from Los Angeles. Outstanding recreational opportunities. Apply Director of Personnel, Seaside Memorial Hospital, Long Beach 13, California.

Matron for modern 8-bed hospital. Salary: $300 per mo. **General Duty Nurse (1).** Starting salary: $240 per mo. with $5.00 increment after each 6-mo. service up to $250 per mo. Full maintenance provided for $30 per mo. Apply to B.E.L. Magnusson, Sec.-Treas., Union Hospital, Hodgeville, Saskatchewan.

General Duty Nurses for Ear, Eye, Nose & Throat Operating Room. Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ontario.

General Duty Nurses & Certified Nursing Assistants for 25-bed hospital in northern Ont. Starting salary: $240 per mo. & $170 per mo. Room & board $28.50 per mo. 5½-day wk. 8-hr. duty. Annual vacation. 1-day sick leave per mo. after 6-mo. Apply Superintendent, Mrs. G. Gordon, District Memorial Hospital, Nipigon, Ontario.

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For further information write or wire:

Director of Nursing,
BROCKVILLE GENERAL HOSPITAL
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